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VOLUME 10 • MARCH 1955 • NUMBER III

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1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Baltimore, Waverly Press, 1952.

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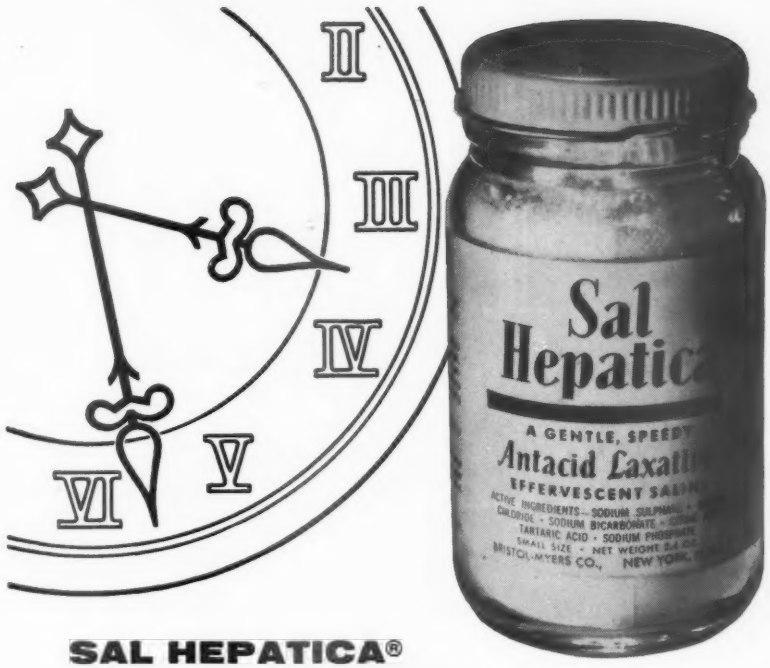

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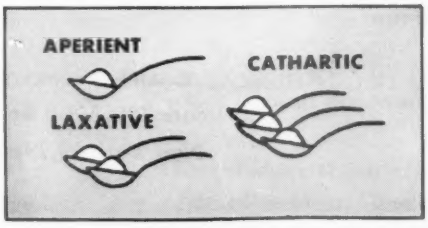

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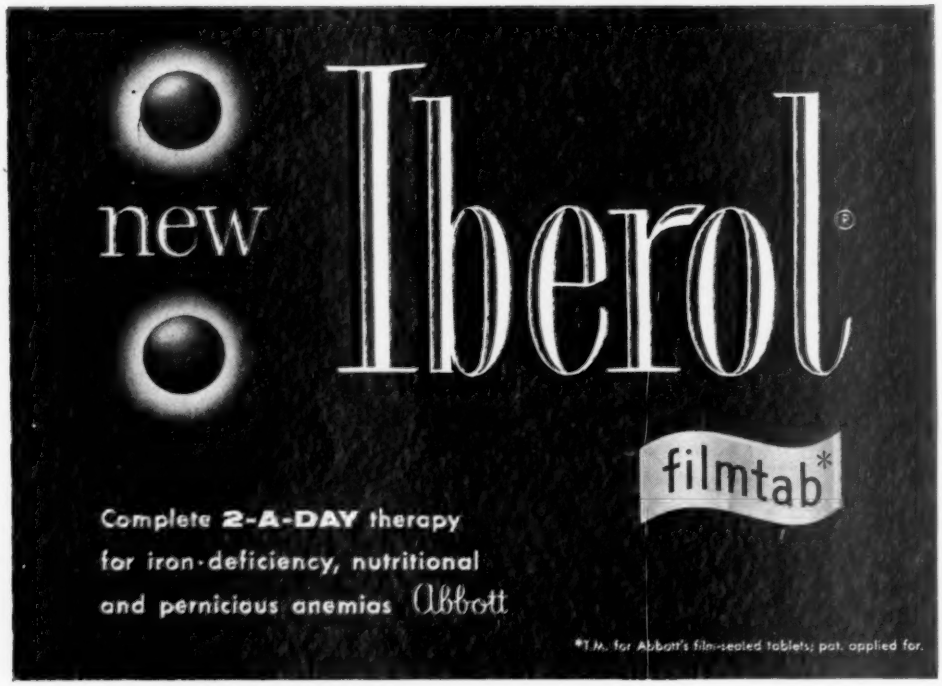

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(Continued on page 17)

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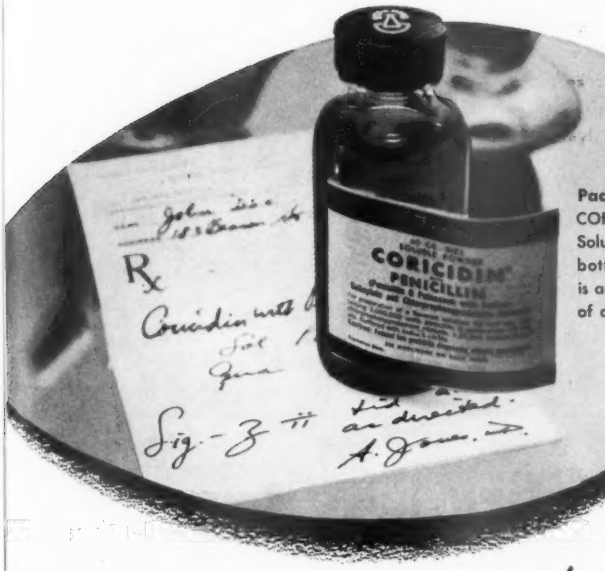

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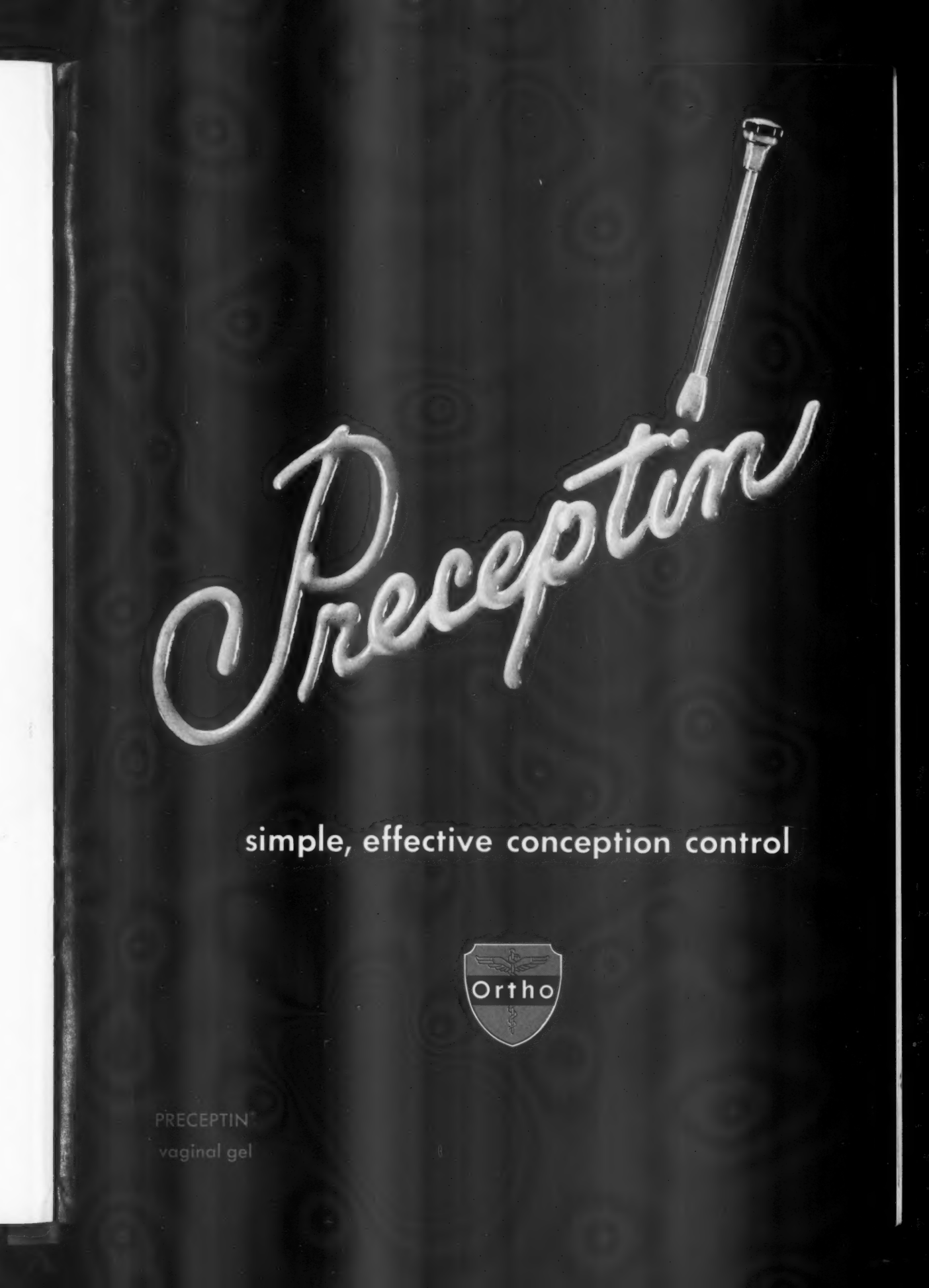
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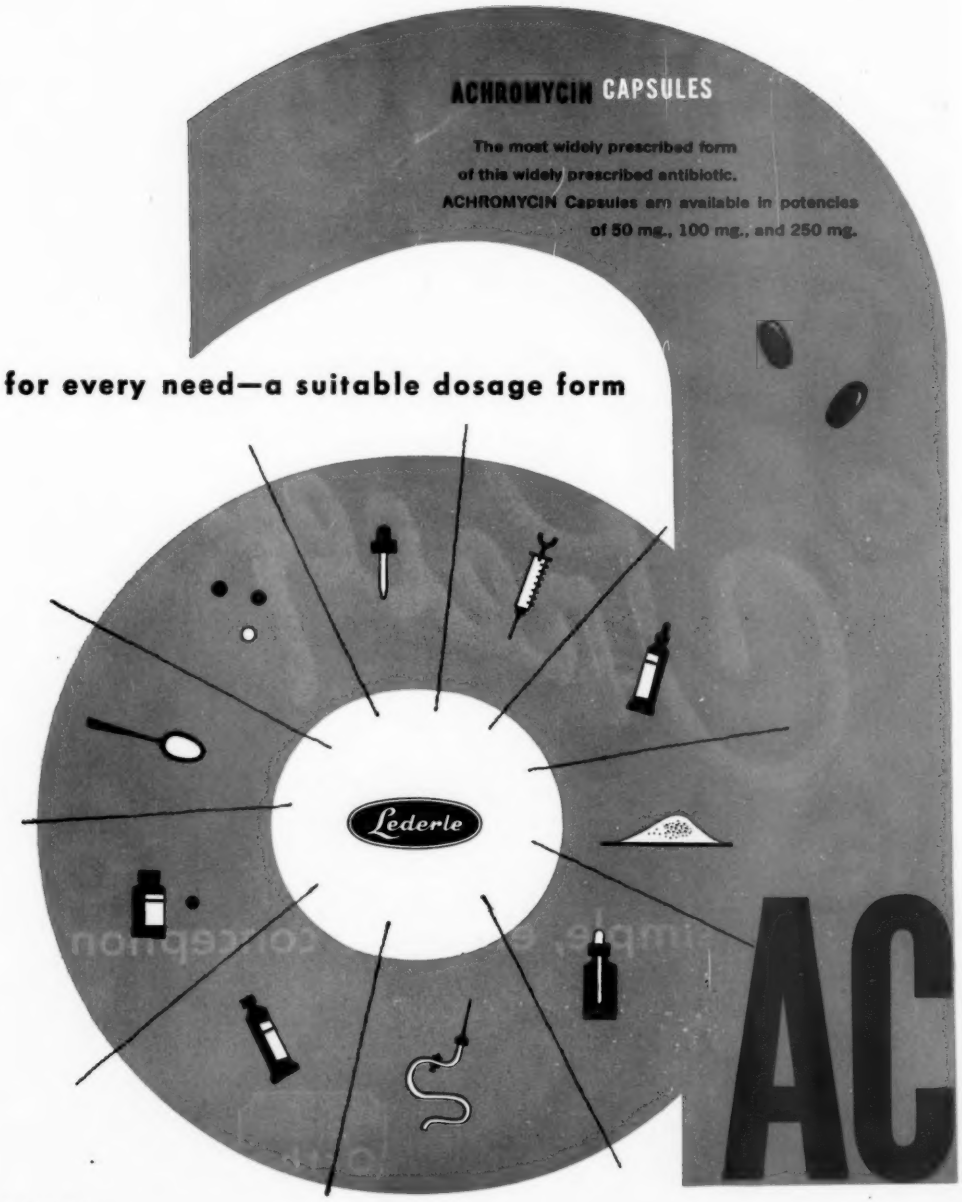
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The complicated chemical structure of a broad-range antibiotic has been successfully tagged with atomic energy, for the first time. The announcement that terramycin® (Chas. Pfizer & Co.) has been labeled for tracer studies with a radioactive isotope known as carbon-14 brings expectation that the elusive answers to important questions regarding the action of antibiotics may be found.

How do antibiotics perform? Are they bactericidal in effect, killing germs by direct action? Are they bacteriostatic, arresting the progress of germs until the body's own natural defenses can take over and finish them off? What happens chemically when antibiotic meets germ? Are antibiotics "blocking agents" which prevent the germ from getting some chemical essential to its life processes? Do they poison the germ? Do they attack indirectly by producing changes in the body which make it impossible for the germ to survive? And what does the body do to the antibiotic: May it be that the antibiotic is changed into still another antibiotic, different in chemical structure, which actually does the work against the germ? How and where is the antibiotic concentrated in the body: does it attack the germ at the site of infection or perform its task in some more indirect manner?

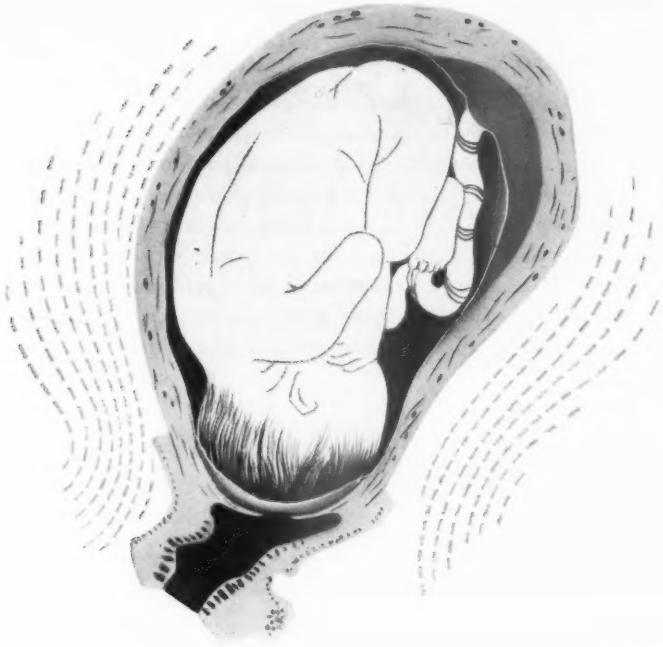
Tagged with radioactive atoms, the molecules that make up terramycin can now be traced as scientists have been tracing similar drugs for some time. The new field of research thus opened may lead to discoveries as to the mode of action of broad-range antibiotics and determine how they produce their life-saving effects. Pfizer scientists had first to determine the molecular structure of terramycin. They then proceeded to try to tag it with atomic energy so that its chemical action in living tissue could be followed with a Geiger counter or other detector of radioactive materials.

As a first step, radioisotopic material was fed to streptomyces rimosus, the organism used to produce terramycin. Through controlled fermentation the carbon-14 isotope is absorbed by the organism and metabolized into the molecule. The next step was to determine which of the carbon atoms in the terramycin compound are radioactive. For tracing, the molecule has to be generally labeled with radioactivity.

Only limited quantities of the radioactive terramycin can be produced now, and it will be six months or more before it can be made available to medical researchers generally.

(Research conducted at the Pfizer Therapeutic Institute, Maywood, N. J., by Dr. J. F. Snell, director; and Drs. Richard Wagner, and Frank A. Hochstein.)

News notes on ATOMIC ENERGY FOR CONSTRUCTIVE USES of interest to the medical profession will appear in these pages from time to time.



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*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

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SURVEY IN AUSTRALIA DISCLOSES TRACHOMA

Heretofore, trachoma has not been officially recognized as existent in Australia. The World Health Organization does not include Australia in the list of those countries which are affected by it. Last year, an ophthalmological survey of the Kimberley District revealed trachoma among both white and aboriginal population of the area to the extent of 41.84 percent of 2,866 persons examined. As a result of the survey trachoma is now reportable. Professor Ida Mann, who conducted the study, has found that sulphonamide preparations have a beneficial effect on the condition which she regards as a result of virus infection. No active case of trachoma was found among patients in a leprosarium who had been treated with sulfonamides. (Condensed from *World Medical Journal,* 2: 19, Jan. '55.)

UNRESTRICTED MEDICAL PRACTICE—INDIA

Among 360 million people in India 60 thousand qualified doctors practice modern medicine against a backdrop of practitioners of every degree, from those whose worth stems from ancient healing lore down to less-than-worthless quacks.

Thousands of years ago, antedating the appearance of medical science anywhere else in the world, Ayurveda—the science of life—developed in India. It was based on the three principles of observation, experimentation, and deduction. It had a philosophy of its own. For medicine, preparations from plants, especially herbs, minerals, and other sources were used. Anatomy and surgery were phases of the science. The learning was handed down from teacher to pupil.

Arabic medicine, known as Unani, appeared with Islamic invasion. Dissection of the human body for the purpose of anatomic study became taboo. The practice of medicine was confined to drug therapy.

Western medical methods were carried by the British into India, at first for the benefit of their own military and civil personnel.

By the turn of the present century many different types of people were practicing medicine in many different ways: Grandmothers, mothers, aunts, and daughters using so-called home remedies; quacks, fakris, and Sadhus; Vaids practicing Ayurveda; Hakims practicing Unani; licentiates from schools of medicine operated for students with basic education insufficient to admit them to qualified medical schools; and, more lately, homeopaths practicing homeopathy.

The high costs of modern medicine and the poverty of the people make the living of the qualified doctor precarious, and it becomes next to impossible for him to practice good medicine. Because of this poverty, politicians and governments are inclined to recognize and encourage all systems of practice, without regard to scientific standards. (Extracted from *N.E. Journal of Medicine,* 252: 18, Jan. '55.)

TB PATIENTS FLOWN FROM ALASKA

Two groups of TB patients have left their native Alaska for treatment in hospitals in the State of Washington. The first plane load of 39 went to Laurel Beach Sanatorium; a second group, flying a week later, are being cared for at Riverton. (*Northwest Medicine,* 54: 60, Jan. '55.)

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 10 MARCH 1955 NUMBER 3

Sarcoidosis*

Bernice Perdziak, M.D., and Gertrude M. Engbring, M.D., F.A.C.P.

IT IS ONLY TWO YEARS AGO that Christian[1] wrote "As one grows old in medicine, he recalls ebbs and flows in the tides of medical interest in various diseases, as evidenced by periods when many articles are published on some specific subject and other periods when interest in that subject seems to wane for months or even years. In the course of time, one can even observe an irregular periodicity of these cycles and mentally plot curves of ebb and flow." Sarcoidosis is a disease that falls ideally into this category. In reading the literature, one finds it was first described about seventy-five years ago,[1a] after which sporadic papers appeared on the subject. In 1934, the Dermatological Reunion[1a] of Strasbourg considered sarcoidosis sufficiently important to devote an entire session to a discussion on it. Since that time, and especially recently, the literature abounds with reports either on a series of cases or on one or more aspects of the disease.

It is all the more phenomenal that sarcoidosis has achieved such tremendous importance, because its etiology is conjectural, the pathology often disputed, and the criteria for diagnosis vary in different sections of the world; the symptoms and clinical course vary in each patient and in the same patient from time to time; it includes a long list of diseases in its differential diagnosis; and the most diversified treatment is used, with questionable success, for sarcoidosis remains a mystery even today.

The disease has been reported in many countries, mainly in Norway, Sweden, Great Britain, United States, France, Germany, Australia, Canada, Japan, Latin America, and Africa. It is not a specialist's disease as one glance at the bibliography assures us, for it has been reported in many journals, representing the following fields: internal medicine, surgery, pathology, dermatology, radiology, cardiology, laboratory and clinical medicine, pediatrics, allergy, diseases of the chest, gynecology, obstetrics, endocrinology, ophthalmology, otology, rhinology, and perhaps a few others.

Not only are the specialties well represented, but the adjectives used to describe sarcoidosis are also numerous. Table I consists of a list gathered at random from the literature.

Sarcoidosis masquerades under many synonyms. Among them are Mortimer's malady, lupus pernio, uveoparotid fever, benign lymphogranulomatosis, osteitis tuberculosa multiplex cystoides, and Besnier-

*Given in part at American Medical Women's Association meeting of Branch Two, Chicago, Illinois, November 1953.

Dr. Perdziak is Clinical Associate in Medicine at Stritch School of Medicine, Loyola University. Dr. Engbring is Associate Professor of Medicine at Stritch School of Medicine, and Attending Physician in Medicine at Cook County Hospital, Chicago.

TABLE I

aberrant	multiform
benign	myriad
bizarre	obscure
confusing	protean
complicated	provocative
curious	paradoxical
diverse	rare
especial	remarkable
erratic	unpredictable
eponymic	unusual
evanescent	unique
interesting	variable
impressive	

Boeck-Schaumann disease. Since the controversy about the disease is great, it is appropriate to indicate that we are primarily concerned with the generalized form of the disease, in contrast to the localized granuloma which occurs as a reaction to a foreign body such as silica, fungi, or even a malignant growth, giving much the same microscopic picture. The generalized granulomatous disease is distinguished by its extensive involvement of several tissues or organs at the same time, its chronic character, and, usually, the mildness of the symptomatology. The minimal or moderate symptoms include tiredness, weakness, anorexia, weight loss, cough, shortness of breath, pains in the fingers or toes, and low grade fever. The patient may experience periods of exacerbation and also spontaneous recovery. Table II lists the organs and tissues involved. No claim is made for completeness as each new article published adds a site for localization of sarcoidosis.

The cause of the disease is obscure; the arguments for and against the tubercle bacillus as the causative organism are almost equally divided. It is perhaps unfortunate that sarcoidosis became associated with tuberculosis early in its history, yet it is understandable since it was only seven years before the first publication on the disease that Koch discovered the tubercle bacillus. Kyrle[2] claimed he was able to demonstrate the acid fast organism in each new crop of lesions, but failed to see them in the older lesions. Because of this, one may draw an analogy to the battlefields: the devastation of war remains but the soldiers who participated are no longer there. His work, however, has not been duplicated. Michelson[3] and Pinner[4] are of the opinion that it is a specific granuloma of unknown origin.

The diagnosis is based on the general symptomatology previously mentioned. Blood chemistry studies are helpful; the most outstanding deviations are an elevated calcium level,[5] hyperglobulinemia, and an elevated serum alkaline phosphatase. Terry and Popper[6] explain the latter on general host reaction and the associated cholangiolitis. Eosinophilia has been reported in about 20 percent of the cases. Sternal marrow puncture was helpful in a case reported by Kennedy,[7] but this finding has not been duplicated so it has limited value. Roentgenography is valuable in detecting lesions of the lungs and small bones. Nitter[8] recently published a monograph on 90 cases with lung involvement, and classified in detail the thoracic roentgen findings into five stages. Most authorities believe a negative tuberculin test is an essential criterion for the diagnosis of sarcoidosis. The Kviem test[9] consists of injecting specific antigenic material prepared from a known case of sarcoidosis into the suspected individual; the typical nodule is produced after a period of six weeks. The nodule is examined microscopically. This test is employed extensively in the Scandinavian countries, but there is much controversy as to its specificity.

Biopsy is the most reliable technique for confirming the diagnosis in this country. The lymph nodes and subcutaneous nodules are the most accessible, and furnish most of the material. Liver biopsy has been successful in 94 percent of the cases as reported by Terry and Popper.[6] Spleen biopsy has been done by Block.[10] An organ or part of an organ has been removed surgically; in our series there is a record of two splenectomies, one biopsy of a lung, and another of a tonsil. Autopsy would be the most accurate diagnostic technique, except that the disease may have healed spontaneously, not an uncommon occurrence. This happened in one of Boeck's cases.[11] The man was 36 years old at the time the diagnosis

TABLE II

1. Skin—including lesions of the nose, ears, hands, feet, and generalized lesions on the body
2. Subcutaneous tissues and perivascular infiltration
3. Mucous membranes
4. Lymph glands, including mediastinal, abdominal, and retroperitoneal
5. Bone—small bones of hands and feet
6. Eye—iris, choroid, lens, retina, cornea, eyelids, eyebrows, lacrimal apparatus; also including uveoparotid and Mikulicz's syndromes
7. Chest
   - Lungs
   - Heart
8. Glands
   - Tonsils
   - Pituitary
   - Parotid
   - Thyroid
9. Abdominal organs and gastrointestinal tract
   - Liver
   - Spleen
   - Kidney
   - Pancreas
   - Stomach
   - Pylorus
   - Ileum (regional ileitis)
10. Nervous tissue—cerebellum and optic tract
11. Genital organs
    - Testes
    - Spermatic cord
    - Prostate
    - Epididymis
    - Endometrium
    - Uterus
12. Miscellaneous
    - Voluntary muscles
    - Ethmoid sinuses
    - Hypothalamus

Fig. 1

Fig. 2

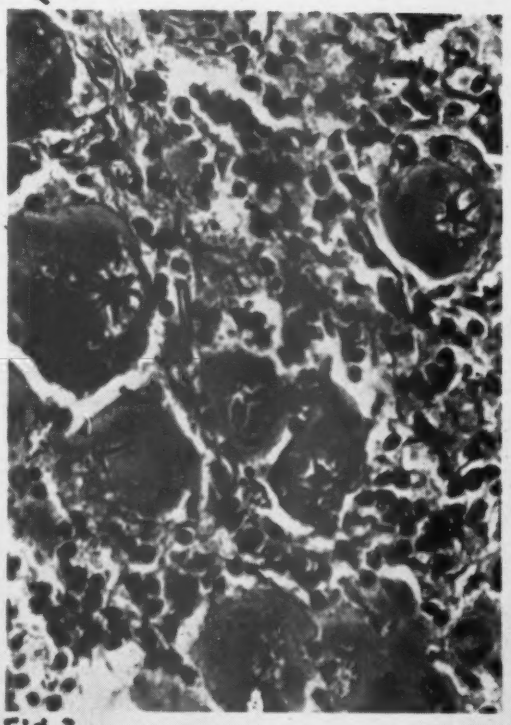

Fig. 3

Fig. 1. Microscopic picture of sarcoidosis in lymph node; note giant cells and palisade arrangement of epithelioid cells surrounded by lymphocytes. Fig. 2. High power magnification revealing giant cell with irregular distribution of nuclei and two asteroid bodies. Fig. 3. This illustrates the abundance of asteroid bodies found in one section.

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was made. He lived to be 80 years of age when he died of a hypernephroma; no lesions of sarcoidosis were found on postmortem examination.

The microscopic appearance of the lesions of sarcoidosis consists of aggregates of large epithelioid cells. Prominent among them are the giant cells; the nuclei of the latter may be located peripherally or dispersed throughout the cell. Lymphocytes usually surround the nests of cells, and there is an absence of caseation necrosis.

Figure 1 is a microscopic picture of sarcoidosis in a lymph node; note the giant cells and palisade arrangement of the epithelioid cells surrounded by lymphocytes. According to Longcope and Freiman[12] there are three types of inclusion bodies. The first is the asteroid or radial inclusion body located in the vacuoles of the giant cells, varying in size from tiny masses with projecting spindles to large star-shaped structures.

Figure 2 is a high power magnification revealing a giant cell with irregular distribution of nuclei and two asteroid bodies. The asteroid body was previously thought to be pathognomonic of sarcoidosis, but it has been found in other granulomata. Figure 3 illustrates the abundance of these bodies found in one section. The second type of inclusion body is the Schaumann body of lamellated or layered hyaline material. The third type is the irregular, poorly staining nondescript body usually found in sections adjacent to skin lesions which have embedded foreign bodies such as silica or glass particles. Each of these has been found in other types of granulomatous diseases such as tuberculosis and beryllium poisoning.

The lesion may take one of three courses: first, it may exist in the epithelioid stage indefinitely or go through periods of progression and regression; second, it may go on to fibrosis; third, it may resolve spontaneously and leave no evidence of its existence. The work of an experienced pathologist is therefore necessary to make a microscopic diagnosis, and correlation with clinical and laboratory findings is essential.

Sarcoidosis has been confused with foreign body reactions with the formation of nodules, and with many other diseases, particularly those in which there is lymph node involvement. Table III includes a list of diseases to be considered in the differential diagnosis.

Our study of the disease is being made at Cook County Hospital, Chicago, Illinois, and from private practice. No attempt is made to produce statistical data, because some patients have had previous hospitalization at Illinois Research and Educational Hospital, Hines Veterans Hospital, Albert Merritt Billings Hospital, and in private hospitals. In some instances the diagnosis was made before the patient was admitted to Cook County Hospital. Many of our patients are Negroes, who frequently migrate to other cities and states. We are aware that with the present interest in the disease a number are probably included in other series. Accurate statistical data would be possible only through organization of a central registry for patients with sarcoidosis.

Since space does not permit the inclusion of all the interesting cases, we have chosen one that illustrates the multiform character of the disease.

Case Report

L. J. R., aged 17 years, first came to our attention in July 1950. She was admitted to surgical service because of abdominal pain and fever of three days' duration. Nausea and vomiting were absent. The pain was located in the right upper quadrant and radiated to the left upper quadrant. She also complained of persistent dryness of the mouth, for which she drank quantities of water, resulting in urinary frequency of about twelve times diurnally and at least eight times nocturnally, with passage of large amounts of urine at each voiding.

TABLE III

1. Tuberculosis	14. Sporotrichosis
2. Infectious mononucleosis	15. Pneumonia
3. Rheumatic fever	16. Beryllium poisoning
4. Lupus erythematosus	17. Silicosis
5. Syphilis	18. Neoplasms
6. Leprosy	19. Erythema induratum
7. Recklinghausen's disease	20. Weber-Christian disease
8. Hodgkin's disease	21. Epidemic parotitis
9. Leukemia	22. Tularemia
10. Brucellosis	23. Diabetes insipidus
11. Histoplasmosis	24. Periarteritis nodosa
12. Torulosis	25. Allergic phenomena
13. Coccidioidomycosis	26. Temporal arteritis.

Although she was 17 years of age, she had not menstruated. She stated that because of frequent colds and swelling of glands in her neck, she had been south each year to attend school.

Past history revealed congenital lues which had been treated adequately, and, in 1946, she had had acute anterior poliomyelitis.

The physical examination revealed a fairly well developed, well nourished Negro female, who appeared much younger than her stated age. She was alert, oriented, co-operative, and not acutely ill. Her temperature was 101 F. orally and had dropped to 98 F. by the next day. Examination of the throat showed deviation of the uvula to the right, a residual of the poliomyelitis infection. There were numerous palpable, nontender, mobile, hard, discrete glands in the posterior auricular, posterior cervical, anterior cervical, and submaxillary areas. A few pinhead sized nodules were palpable, but not visible on the left cheek. Two subcutaneous nodules as large as peas were palpable over the left deltoid region. The skin appeared to be intact, and did not show any areas of edema, erythema, or pigmentation. She had no axillary or pubic hair. The patient stated that pubic hair started to grow before she contracted poliomyelitis, but growth stopped at that time and she noticed the loss of pubic hair following this illness.

Blood pressure was 80/60; apical rate was 80; regular rhythm; pulmonic second sound was increased over the aortic second sound; no apparent cardiac enlargement; and no murmurs were heard. There was moderate tenderness in the left upper quadrant. The tip of the spleen was palpable, the liver edge was felt one finger-breadth below the right costal margin. The large quantities of water consumed by the patient suggested the necessity of an endocrine evaluation, so the patient was transferred to a medical ward.

The chart on the previous admission in 1946, with diagnosis of acute anterior poliomyelitis, was reviewed. At that time she had complained of sore throat, headaches, abdominal pain, and vomiting of five days' duration. Pain was diffuse over the entire abdomen, intermittent, lasting about two days; it was associated with vomiting about six times each day. A "stiff neck" was present three days before admission. The temperature ranged from 100.6 F. rectally to 102 F. There was nuchal rigidity and positive Brudzinski's and Kernig's signs; absence of abdominal and patellar reflexes; spasm of the hamstring muscles; and minimal

TABLE IV. BLOOD CHEMISTRIES

Dates—1950	Aug. 4	Aug. 8	Aug. 16	Aug. 25	Aug. 28
Non protein nitrogen mg. 100 cc.	36				
Total proteins Gm. 100 cc.			7.3	7.4	7.0
Albumin Gm. 100 cc.				3.4	4.1
Globulin Gm. 100 cc.				4.0	2.9
Inorganic phosphorus mg. 100 cc.					4.8
Cholesterol mg. 100 cc.					164.0
Alkaline phosphatase (Bodansky Units)					2.2
Icteric index (units)					5.0
Chlorides mEq/liter		106	102	106	
Sodium mEq/ liter		150	146		
Potassium mg. 100 cc.		16.7	15.7		
Cephalin flocculation					0.0
Thymol turbidity					6.0
Gamma globulin Gm. 100 cc.					1.55

abdominal tenderness. Liver and spleen were not palpable; no notation about adenopathy was made during this admission.

During her 1950 hospital stay, and subsequent visits, the following tests were performed (see Table IV):

Basal metabolism tests were as follows (Table V):

TABLE V

Date	B.M.R.	Weight	Pulse	Temperature F. orally
Aug. 9	-12	98	88	98
Aug. 10	-10	98.75	78	97
Aug. 14	-14	99	72	97.4
Aug. 16	-12	101.5	84	98.6

Radioactive iodine uptake was 11 percent; the fasting blood sugar was 60 mg. per 100 cc. and a glucose tolerance curve was flat; a hemogram was performed in August 1950 (see Table VI):

TABLE VI

		Date	Corrected Sedimentation Rate	Hematocrit
Hemoglobin	81%			
Red blood cells	4,200,000			
White blood cells	7,400			
Neutrophils	38			
Bands	4			
Eosinophils	28			
Lymphocytes	30			
Anisocytosis	1 plus	Aug. 7	24	38
Toxicity	1 plus	Aug. 14	29	40
		Aug. 16	14	40

A Thorn test with the injection of 25 mg. of ACTH intramuscularly was done on August 20, 1950. The white cell count was 9,400 per cu. mm. At 9:00 a.m. the level of circulating eosinophils was 2,112 per cu. mm. Four hours later, at 1:00 p.m. it was 2,068 per cu. mm. It was repeated on August 25. At that time, the circulating eosinophils were 2,871 per cu. mm. and four hours later, at 5:00 p.m., were 2,882. This test was repeated again in 1952 when the initial eosinophil count was 2,440, and the level of circulating eosinophils was 2,700 per cu. mm. four hours later. A modified Thorn test, giving 5 mg. of ACTH by intravenous drip, resulted in an original count of 1,659 per cu. mm.; the final count was 293 per cu. mm.

The urine was almost water-clear in color, had a specific gravity of 1.000 to 1.006, was negative for sugar, albumin, and showed no abnormality on microscopic examination. The urinary output varied between 6,800 cc. to 8,000 cc. in 24 hours, and the fluid intake was in the vicinity of 7 to 10 liters per day.

A Robinson-Power-Kepler water test[12,13] was carried out on August 21, 1950 (see Table VII):

Procedure II was carried out four days later. (See Table VIII):

TABLE VII. PROCEDURE I

Hour	Amount	Specific gravity
10:00 p.m. to 7:00 a.m.	2,200 cc.	1.006
8:00 a.m. before water	170 cc.	1.005
9:00 a.m. after 1,000 cc. of water	120 cc.	1.004
10:00 a.m.	220 cc.	1.004
11:00 a.m.	210 cc.	1.004

TABLE VIII. PROCEDURE II

Urinary urea nitrogen in night specimen	75 mg. percent
Fasting plasma urea nitrogen	8 mg. percent
Fasting plasma chlorides	106 mEq./liter
Urinary chlorides in night specimen	19 mEq./liter
Volume of largest hourly specimen	220 cc.
Volume of night specimen	2,060 cc.
Calculation, using the formula, value of	3.6[12,13]

(This is extremely low and difficult to interpret.)

An electrocardiogram taken in 1950 shows low voltage, a rate of 80, sinus arrhythmia, P-R interval of 0.16 second, QRS complexes of 0.05 second, and inversion of T waves in lead III and the precordial leads. This at first was thought to be a juvenile pattern compatible with her age, but the tracing is almost identical with one taken in 1953 and 1954. Fig. 4 illustrates the electrocardiogram taken in 1953.

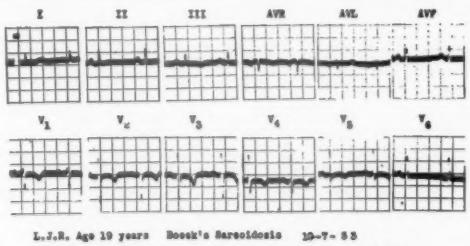

Fig. 4. Electrocardiogram taken in 1953.

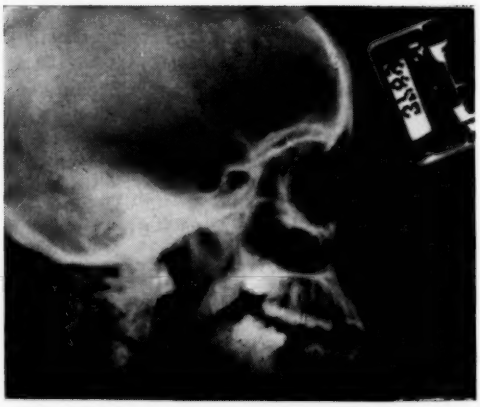

Fig. 5 illustrates a roentgenogram of the skull showing no osseous abnormality and a normal sella turcica.

A Kahn blood test was negative. A tuberculin intradermal test in a dilution of 1: 10,000 was negative. A histoplasmin intradermal test was negative. The fundi and central and peripheral visual fields were normal. Twenty-four hour determinations of 17-ketosteroids on three different occasions were 4.1, 7.8, and 9.4 mg. Uterine scrapings revealed an endometrium with very few glands and a low columnar epithelium. An electroencephalogram taken in 1952 was normal.

Numerous biopsies were done on lymph nodes and subcutaneous nodules, revealing nests of epithelioid and giant cells. There was no caseation and no inclusion bodies were found.

The roentgenogram of the chest in Fig. 6 shows the heart and aorta to be of normal size. There are increased shadows suggestive of adenopathy in both hilar regions. The lung markings are increased bilaterally especially around the hilar regions. There is little or no change in the chest roentgenogram taken two years later as shown in Fig. 7. Roentgenograms of the hands were negative in 1950, but a roentgenogram of the feet revealed a hazy bony lesion in the first phalanx of the third toe on the right foot. (Fig. 8). This has progressed and is a definite punched-out area on films taken in 1951 and 1952, illustrated in Fig. 9.

The only therapy the patient received was one-half grain of thyroid daily and multivitamins, both of which she discontinued of her own accord.

This patient exemplifies progression of the disease. After her dismissal from the hospital in 1950, she developed a new bone lesion in the middle phalanx of the fifth digit on the left hand. This occurred without any external evidence of skin lesion. Late in 1952, she complained of excessive lacrimation and spots blurring her vision in the right eye. Late in 1953, she noted a swelling in the left hand, fifth digit. Her voice was hoarse. The lesions on her left cheek became more numerous and involved the superficial layers of the skin, resulting in a violaceous, plaque-like area covering the entire left cheek. The picture (Fig. 10) taken in 1953, shows small pinhead nodules which were elevated and felt like coarse sandpaper.

In June 1954, the patient was readmitted to the hospital because of a 10 pound weight loss, anorexia, severe headaches, dizzy spells, hoarseness, increased size of the lesion on the face, and the development of new subcutaneous nodules. They varied in diameter from pea to marble size, on the left arm, both legs, and right breast. She had exertional dyspnea, was lethargic, and somewhat depressed.

Her blood pressure was 80/50, weight 88 pounds. Absence of axillary and pubic hair persisted and skin and subcutaneous lesions were as described above. Breath sounds were harsh, sinus arrhythmia was present, and the liver was two fingerbreadths below the right costal margin. Menstruation had not commenced.

An intradermal tuberculin test in a dilution of 1:1,000 was negative in 24 and 48 hours. The urinary output was 6,800 cc. and the intake was 7,800 cc. in 24 hours. An electrocardiogram showed the same changes as in 1953 (see Fig. 4). An eye consultant reported a low grade uveitis in the right eye.

Blood chemistries done in 1954 showed: total proteins 7.9, chlorides 85 mEq. per liter, sodium 134 mEq. per liter, potassium 4.1 mEq. per liter, cholesterol 200 mg. per 100 cc.; icteric index was 6 units, cephalin flocculation 1 plus, thymol turbidity 7.6, and gamma globulin 2.16 Gm. per 100 cc. One week later the total proteins were 7.1 Gm. per 100 cc., albumin 4.8 Gm. per 100 cc., and globulin 2.3 Gm. per 100 cc. The chlorides rose to 107 mEq. per liter, sodium to 139, and potassium level was 3.6 mEq. per liter.

After six weeks of bed rest, the patient showed no improvement. It was decided to use cortisone therapy. Twenty-five mg. three times a day, or 75 mg. daily, and 500 mg. of streptomycin intramuscularly every other day, were started July 17. Five days after cortisone therapy was begun, the subcutaneous nodules began to decrease in size and finally disappeared, leaving the skin smooth and normal. The lesion on the face became softer, less elevated, and to a certain degree cleared. The violaceous appearance was less marked. The girl became euphoric, industrious, and talkative for the first time since her last admission. Her voice seemed much less hoarse. In three weeks there was a weight gain of five pounds and slight "mooning" of the face, therefore cortisone was decreased to 50 mg. per day, given in two doses. Two weeks later the fluid intake was 5,100 cc. and the urinary output was 5,800 cc. Her weight increased to 107 pounds, and so cortisone was decreased to 12.5 mg. per day. She was dismissed from the hospital on this dosage and 500 mg. of streptomycin twice a week. While at home she developed two indurated areas, one on each buttock, where streptomycin had been administered. The induration persisted for about three weeks, gradually disappearing, at no time becoming fluctuant.

Fig. 11 shows the most recent picture of the face, with the lesion much smaller, smoother, and softer. Fig. 12 illustrates the cystic areas in the phalanx of the fifth digit of the left hand. There were no new lesions in the bones of the feet. Fig. 13 is a recent roentgenogram of the chest after cortisone therapy, demonstrating an increase in the size of the heart and also in fibrosis of the lungs. The apices remain clear. Cortisone therapy has had a beneficial effect on new lesions and a questionable one on the older lesions, probably leading more rapidly to fibrosis.

All therapy has been stopped for the past six weeks. The patient has on two occasions recorded the fluid intake and the urinary output. The last one submitted was: intake of 2,600 cc. and output of 1,600 cc., per 24 hours. This indicates a considerable decrease in comparison with the record of six months ago.

During a visit to New York, the patient learned that a cousin of hers, whom she met for the first time, also has sarcoidosis, involving the skin, lungs, and bones.

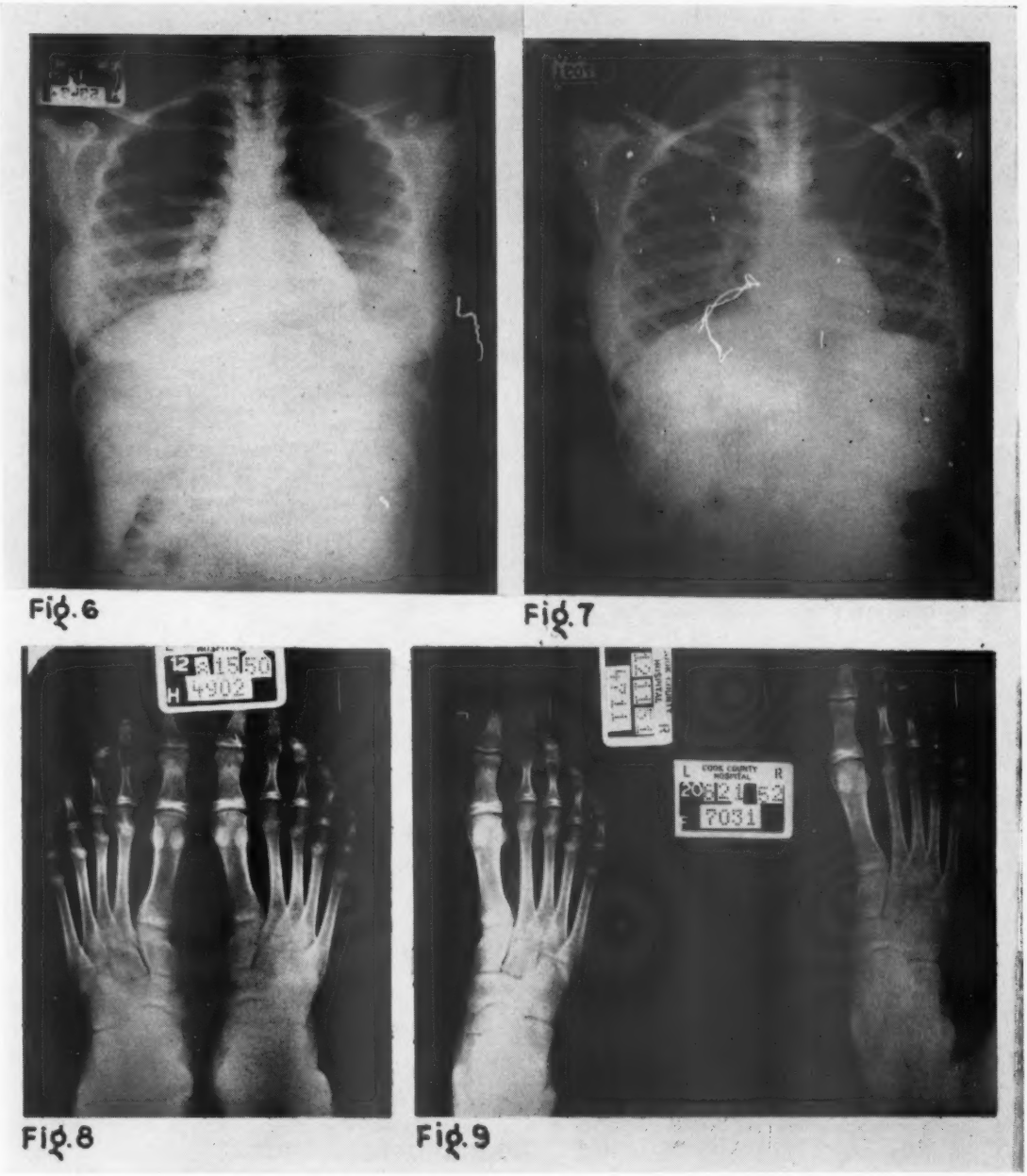

Fig. 6. Roentgenogram of chest, taken in 1950; heart and aorta are normal size. Increased shadows in both hilar regions. Fig. 7. Roentgenogram of chest in 1952; shows no change. Fig. 8. Roentgenogram of feet in 1950; reveals lesion in first phalanx of third toe of right foot. Fig. 9. Roentgenogram of feet taken in 1951 and 1952; note punched out area indicating progression of lesion on right foot.

Summary

This patient is an example of generalized sarcoidosis with wide dissemination and involvement of many tissues and organs. The hypopituitarism is postulated to be the result of sarcoidosis, involving both the anterior and posterior pituitary, manifested by diabetes insipidus, hypothyroidism, and absence of ovarian function. There is involvement of skin, lymph nodes, and subcutaneous tissues, evidenced by biopsy specimens. Roentgenogram reveals the involvement of lung parenchyma, peribronchial nodes, and lesions in the small bones of the left hand and right foot. Nodules in the heart could conceivably produce the sinus arrhythmia, and changes in the electrocardiogram. Eosinophilia has been reported frequently and is also present in this patient. The presence of lacrimation, hoarseness, and uveitis could also fit into the picture of this variable disease.

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Fig 10

Fig 11

Fig. 12

Fig. 13

Fig. 10. Skin lesion, showing small, elevated, pinhead nodules on left cheek; picture taken in 1953. Fig. 11. Note lesion is smaller, smoother, softer, after cortisone therapy; picture taken in 1954. Fig. 12. Roentgenogram, taken in 1954, shows cystic areas in phalanx of fifth digit of left hand. Fig. 13. Roentgenogram of chest taken in 1954 after cortisone therapy. Shows enlargement of heart and increased fibrosis of lungs.

CASE REPORTS

Rheumatic Fever with Carditis

WITHDRAWAL EFFECTS FOLLOWING CORTISONE THERAPY

Anne L. Bohning, M.D.

SINCE THE DISCOVERY THAT, with hormone therapy, it was possible to suppress the exudative phenomena of rheumatic fever, cortisone has been widely used. There is still, however, considerable confusion as to the proper method of administration and the ultimate effects. It was hoped that hormone therapy might prevent, or at least lessen, the severity of carditis. It has become increasingly clear that it does not prevent carditis, although in some cases hormone therapy has appeared to arrest the carditis, and at times to be even life saving.

In a large group of cases, a rebound has been seen to occur at the time of the withdrawal or decrease of the hormone. We are presenting the history of such a case. In many cases, the rheumatic process seems to be even more severe than it was before treatment. In rare instances death has occurred, even though hormone therapy was resumed.

CASE REPORT

E. M., white male, aged 9 years, had seemed well until late in October 1953, when he had complained of pains in his chest and had some fever. After a few days of bed rest, he recovered without any specific therapy. No joint swellings were observed. He was normally active until November 2 when he awoke and complained of feeling ill. His temperature was 102 F. He was kept in bed for several days more but still seemed ill. When he was first seen by the referring physician on November 5, the lungs were clear and no heart murmurs were heard. He was sent to a general hospital where he was given cortisone, aspirin, and penicillin. During his stay in this hospital, a heart murmur was detected and a chest roentgenogram showed the heart to be enlarged. His temperature continued elevated. A diagnosis of rheumatic fever was made, and on November 27, 1953, he was transferred to LaRabida Sanitarium for further treatment.

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Physical examination on admission to LaRabida showed a well developed boy who did not appear acutely ill. He had no pain. He was pale, but there was no cyanosis and no dyspnea. His temperature was 102 F. His heart rate was 110. There was a soft blowing systolic murmur at the apex. There was also a very low-pitched early diastolic murmur at the apex. Chest roentgenograms taken on admission showed "pneumonitis with minimal reaction at the base of the left lung, with moderate cardiac enlargement." An electrocardiogram on November 30, 1953 (Fig. 1A), was not remarkable. The erythrocyte sedimentation rate was 51 mm. in one hour. The hemoglobin was 12 Gm.; the red blood count was 3,890,000; the white blood count was 11,550. The diagnosis was active rheumatic fever with carditis.

Cortisone therapy was started immediately. He was given 50 mg. every eight hours and potassium chloride 0.9 Gm. every eight hours.

The temperature came down rapidly and the blood count returned to normal. In two weeks the sedimentation rate was 8 mm. in one hour and remained within normal limits until January 20, 1954, when it rose to 40 mm. At this time the dose of cortisone had been reduced slightly. The sedimentation rate became normal on February 3, and continued normal until the dose of cortisone was again reduced on February 16. The patient was, however, still receiving 50 mg. of cortisone daily, when, on March 6, he complained of pain in his chest and left shoulder. His temperature rose sharply to 104 F. and his pulse to 140. He became dyspneic and was given oxygen. The dose of cortisone was increased to 150 mg. daily. A chest roentgenogram on March 8 (Fig. 2 B) showed the heart to be greatly increased in size and the left costophrenic angle to be obscured. A roentgenogram five days before (Fig. 2 A) had shown the heart to be of normal size and the lungs clear.

The electrocardiogram had shown very little change since admission (Fig. 1 A), except that the rate had become slower, but, at the time of this rebound, the rate increased to 150 and T_3 changed from isoelectric to inverted (Fig. 1 B). At this time digitalis was started. On the following day, March 9 (Fig. 1 C), T_3 became smaller and T became inverted in leads V_{2}, V_3, and V_4. T also became smaller in V_5 and V_6. These changes could not have been caused by digitalis, since it had not been started until late the day before. On

March 11 (Fig. 1 D), T_1 became still smaller and T_2 became definitely inverted. The T in aVr became upright and T in aVf became more deeply inverted. T became more deeply inverted in V_2, V_3, V_4, and V_5, and the T in V_6 was diphasic. These marked T wave changes are somewhat similar to those seen with pericarditis, but in our patient no friction rub was heard. The electrocardiographic changes do, however, indicate definitely that the myocardium was in some manner seriously affected.

At the time of this rebound, the sedimentation rate rose to 52 mm.; but when the dosage of the cortisone was increased, it returned promptly to normal.

On March 9 (Fig. 2 C), the chest roentgenogram showed the heart to be slightly smaller than on the day before, but it was still considerably enlarged and the left costophrenic angle was still obscured. By March 11 (Fig. 2 D), the film showed the heart to be definitely diminished in size, although still somewhat larger than normal. The lungs seemed clear at this time. It is interesting to note that on the day this roentgenogram was taken, the electrocardiagram showed marked inversion of the T waves (Fig. 1 D).

In a few days, the patient seemed clinically recovered and no longer needed oxygen. Digitalis was continued in maintenance dosage. By March 15, the sedimentation rate had returned to normal and remained so for the next eight weeks.

An electrocardiogram on March 17 (Fig. 1 E) showed improvement in the T waves. T had become upright again in leads I, II, and III, in V_2 and in V_3 had become diphasic; T in V_4, V_5, and V_6 had become upright. By April 7 (Fig. 1 F), the electrocardiogram had almost returned to its earlier contour, resembling that taken on November 30, 1953 (Fig. 1 A). Weekly electrocardiograms were esssentially the same for the next few weeks.

The patient seemed to be doing very well and all tests had become stabilized, and so on April 4 digitalis was discontinued. On April 20 a gradual decrease of cortisone was again ordered. The temperature, pulse, and sedimentation rate remained normal until May 25, when the patient again complained of pain in his chest. The temperature suddenly went up to 104 F. and his pulse to 148. He became dyspneic. At this time he was still getting 50 mg. of cortisone daily.

The chest roentgenogram on May 25 (Fig. 2 F) again showed an increase in heart size, although since May 14 the heart size had been normal, appearing much the same as in the one taken on April 8 (Fig. 2 E). The electrocardiogram on May 25 (not shown) was almost the same as that on March 11 (Fig. 1 D) with similar T wave changes. The sedimentation rate was 45 mm. The white blood count was 14,350. No friction rub was heard, but a harsh systolic murmur was audible at the apex.

Cortisone was immediately increased to 200 mg. daily and the patient was again given digitalis. As

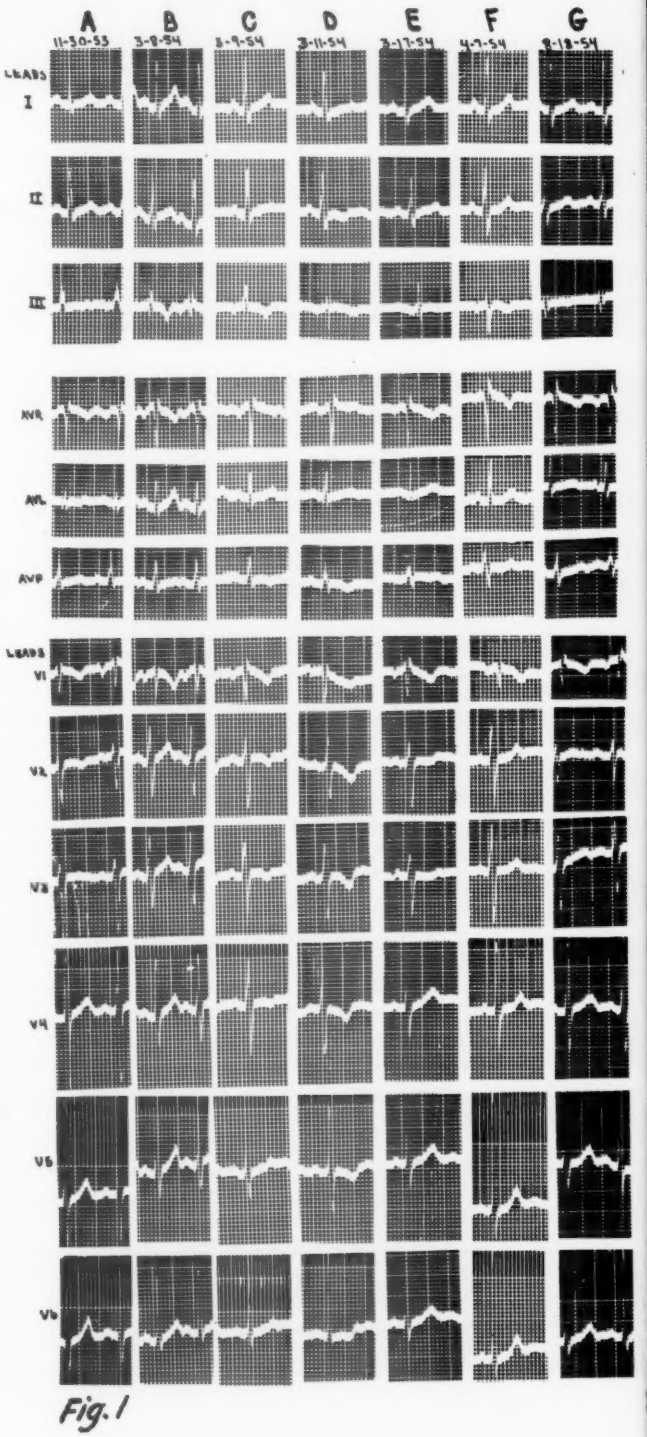

Fig. 1

Fig. 1. A. Rate 115, P-R=0.16, QRS=0.06. B. Rate 150, S-T_2 is elevated. T_2 has become inverted. C. Rate 107, T_2 is smaller. T is inverted in aVf and in V_2, V_3, and V_4. D. Rate 75. T_1 is smaller. T_2 and T_3 are inverted. T has become upright in aVr. T is more deeply inverted in aVf. T is more deeply inverted in V_2, V_3, and V_4. T has become inverted in V_5 and diphasic in V_6. E. Rate 65. T waves show some recovery. F. Rate 75. T waves show almost complete recovery. G. Rate 100. Curve is essentially the same as it was on admission.

before, he made a rapid recovery and clinical findings returned to normal in a few days. By three weeks, the sedimentation rate had returned to normal. The electrocardiogram gradually returned to the previous contour. By June, the chest roentgenogram showed the heart and lungs to be of normal appearance. Digitalis was discontinued early in July. Cortisone was again decreased and finally discontinued on July 18. This time the temperature, sedimentation rate, heart size, and electrocardiogram remained stabilized. The patient was given gradually increased activity and had an uneventful convalescence. On August 18 (Fig. 1 G), the electrocardiogram was essentially the same as on admission. On September 7 the patient was discharged from the hospital. He has remained well since then without any other medication than prophylactic sulfadiazine, one Gm. daily.

Summary

We have presented the history of a patient with active rheumatic fever and carditis, who was treated with cortisone. He received cortisone for about three months and his clinical and laboratory findings became stabilized. When hormone therapy was decreased, he had a rebound and became dangerously ill, with a recurrence of rheumatic fever symptoms and cardiac failure. When the dosage of cortisone was increased, these symptoms subsided almost immediately. Cortisone was continued for another six weeks. When hormone therapy was decreased a second time, there was again a recurrence of the symptoms of rheumatic fever. Cortisone therapy was resumed and continued for another six weeks. The clinical and laboratory findings again became normal and remained so even after cortisone was finally discontinued. The patient seemed to have made a good recovery with only moderate damage to his heart.

Discussion

Taran* has stated that "it is our impression that cortisone and ACTH therapy in many instances may be provocative and in some instances reverse the rheumatic process and increase the severity." He found that over one half of his patients showed definite withdrawal effects or "rebound phenomena" following termination of the course of treatment. In his experience, this was observed more often after cortisone than with ACTH therapy. He found that with either cortisone or ACTH the incidence of withdrawal effects was greatest when the carditis had been severe before therapy was started. He also observed these effects to appear when the dose of the hormone was decreased, but not entirely discontinued. In our experience, the "rebound phenomena" were usually a rise in temperature, an increase in heart rate, a rise in the sedimentation rate, and, in some instances, an increase in heart size and abnormal electrocardiographic findings. In several cases we have seen joint swellings. There may be also pain, dyspnea, and heart failure, as in the case described. If hormone therapy is started promptly again in adequate dosage along with other supportive measures, the patient usually improves rather promptly. However, in the case here reported, the "rebound phenomena" occurred again when cortisone was decreased a second time. Whether the cortisone dosage was not adequate is a question that will bear further study. In other instances, we have seen an increase in sedimentation rate and heart rate without any of the more serious symptoms. In most cases the tendency has been to improve without other therapy than a longer period of bed rest. Such rebounds have also been observed after discontinuing aspirin therapy. Many patients have no rebound effects that can be detected. Whatever the therapy, it seems wise to decrease the dosage of the specific drug gradually.

Why this rebound occurs in some cases is not well understood. No satisfactory explanation has been presented, although various theoretical speculations have been offered. In our experience it has not been possible to predict which cases may develop this rebound. It may be related to dosage or the length of time of administration of the specific type of therapy, or it may be related to some unknown factors peculiar to the effect of the disease on the individual and his response to therapy.

This case serves to illustrate the inadequacy of small doses of cortisone. It does not indicate that cortisone is not effective in the treatment of rheumatic fever, but it does show that, in our present state of knowledge, we are still uncertain as to the most effective method of treating rheumatic fever. Many believe that aspirin still has its place as a useful drug in the treatment of rheumatic fever. Until further studies and more experience amplify our knowledge concerning the nature of this disease and the effects of hormone therapy, each case must be given individual consideration and treatment.

Fig. 2. A. March 3, 1954. The heart measurements are within normal limits. B. March 8. The heart has increased in size and the left costophrenic angle is obscured. C. March 9. The heart appears slightly smaller, although still enlarged to left. D. March 11. The heart has definitely diminished in size. It measures 30 percent oversize. Lungs are clear. E. April. 8. Heart now appears to be of normal size and lungs are clear. F. May 25. Heart has increased in size.

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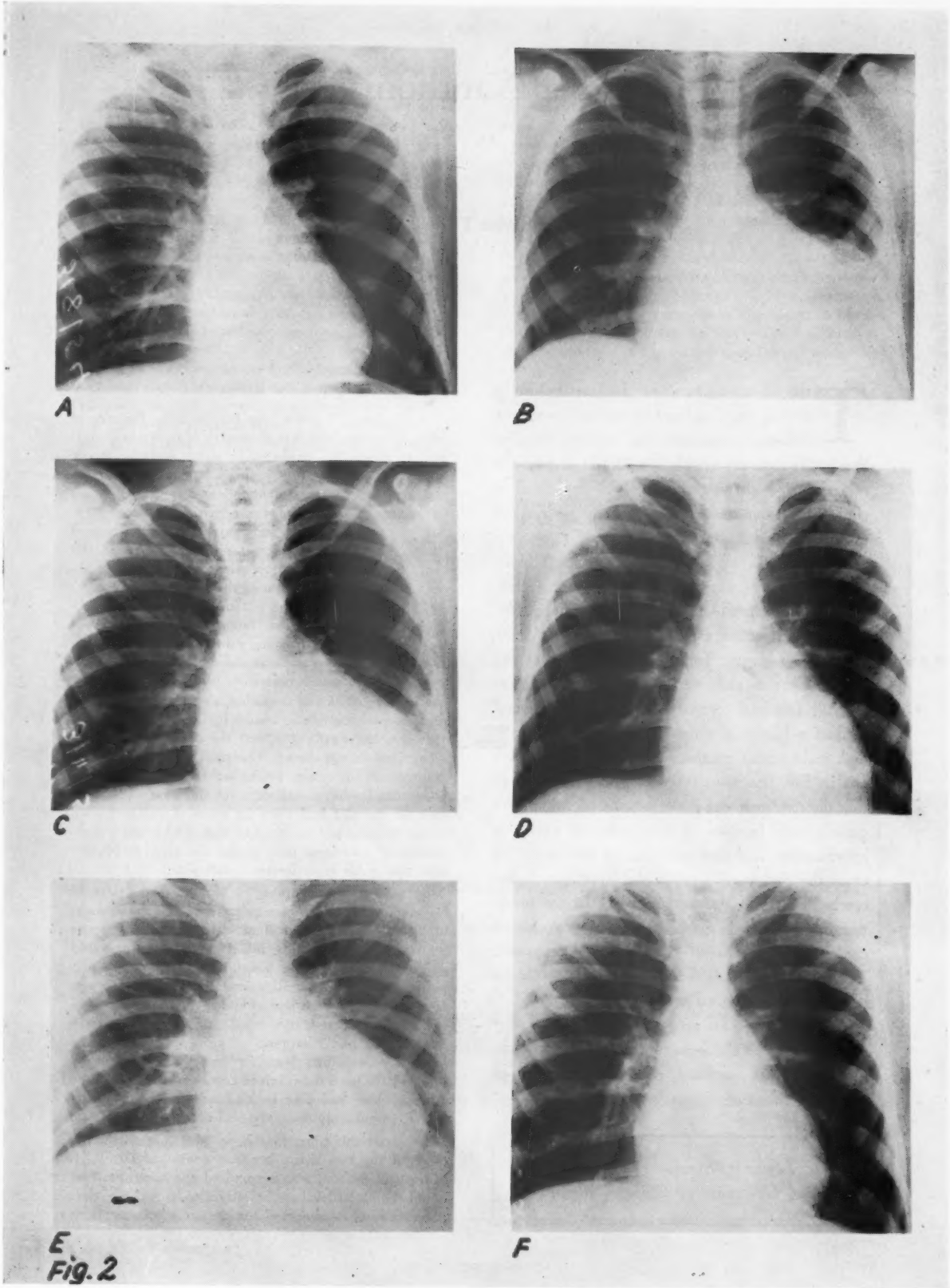

Fig. 2

Familial Xanthomatosis

Ruth Elaine Taylor, M.D.

THE CONSIDERATION OF fat metabolism is now in the forefront of medical problems. Atherosclerosis, with its frequent localization in the coronary vessels, is a subject of intensive research. The attempt to control the deposition of cholesterol is an interesting possibility which up to now has had but indifferent success.

The incidence of xanthoma tuberosum is so infrequent as to be noteworthy. The genetic implication of the condition has been recognized since 1893, and some fifty cases, with strong familial incidence, have been reported. In one family, a mother and four of her nine children had xanthoma tuberosum and all five had coronary heart disease. Alvord[1] studied a family in which there was an unusually high incidence of coronary disease and xanthomatosis in five, possibly six, generations. He believed that the condition was the expression of a dominant genetic trait. In none of those affected was there hypertension, and diet appeared to have no effect upon the cholesterol level in the blood serum. Recently Bruins,[2] of Amsterdam, reported the condition in monozygotic twins. In both cases the serum cholesterol was between 415 and 465 mg. percent. These cases showed no features different from those of other cases described in the literature.

The following case report is that of a member of a family of six children, four of whom apparently suffered this condition, three of whom, in all probability, died of coronary occlusion.

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CASE REPORT

B. B., aged 37 years, was first seen in January of 1944. Her complaint was of neuritis of the right arm. It had troubled her periodically since early girlhood; attacks were apparently induced by unusual exertion and her most severe attacks followed each of her two deliveries. No source of the neuritis was discovered. All of the laboratory findings were within normal limits. Serum cholesterol was not determined at this time, however. On fluoroscopic examination, no abnormality in size or shape of the heart was noted.

Three years later, the patient complained of substernal pain on exertion. Some enlargement of the heart was noted at this time on fluoroscopic examination. A systolic murmur was also recorded and an electrocardiogram was reported as follows: Normal A-V conduction, right axis deviation, slurring of QRS complex, normal ventricular conduction, and sinus rhythm.

It was not until 1949 that the family history was recognized as significant. The patient stated that her youngest brother was beginning to develop nodules about the tendon attachments of the hands and feet, such as she had had since 18 years of age and such as she believed her mother had had. This brother complained of substernal pain, as did also another brother who was in his early forties at this time.

Because of the possibility of familial disturbance of fat metabolism, B. B. was referred to the department of cardiology at Billings Memorial Hospital in Chicago for study of blood lipids. Blood cholesterol was found to be 426 mg. percent. Total lipids were 1,155 mg. percent. Further investigation, through the former family physician who had attended the patient's mother for many years before her death, revealed that the mother had had symptoms of coronary insufficiency for many years and that her death was thought by him to have been the result of coronary occlusion. One other brother had died in his late thirties of a heart attack, presumably coronary occlusion.

At about this time, that is, in March of 1949, the elder of the two living brothers consulted Dr. R. J. Morton of Seattle, who recognized the condition and found the blood level of cholesterol to be 453 mg. percent. His symptoms were of coronary insufficiency, from

which he died in 1952. In 1949, the youngest member of the family, a man in his early thirties, was studied at a Veterans Administration hospital on the west coast. He had substernal pain, which was diagnosed as a psychosomatic disturbance induced by inability to adjust happily to army life. The tendon nodules were noted, however, and a cholesterol level of 340 mg. percent was found.

After learning this much of the family history, the heart condition of B. B. was again evaluated. The electrocardiogram showed no significant change since 1944. Blood pressure was 120 systolic and 70 diastolic. There was no significant change in the patient's condition up to the time of her sudden death, which occurred in 1951 while she was walking against a driving wind in a blizzard.

Most significant autopsy findings were in the cardiovascular system. Cardiac dilatation with severe coronary sclerosis and multiple infarcts explained the clinical course and terminal event. The heart muscle, particularly that of the ventricles, was permeated and replaced with fatty tissue, in places comprising half the ventricular wall. The aortic valve was quite unusual. Atheromatous thickening converted the basal portion of each cusp into stiff yellow cups. In contrast, the margins of the cusps were soft and pliable. The aorta was sclerotic throughout the ascending portion and arch. Atherosclerosis disappeared in the descending thoracic portion, except for rings narrowing the mouths of the intercostal arteries. It reappeared at the diaphragm to reach maximal severity in the abdominal aorta. The heavy involvement of the abdominal aorta narrowed the mouths of all the branches of the abdominal vessels. There were no true aneurysms and no evidence of recent thrombi. However, the left iliac artery showed evidence of a healed thrombus.

The vascular system of the brain showed nothing unusual except atherosclerosis of the circle of Willis.

Additional findings included xanthomatous nodules, rich in lipid material, most numerous over the extensor tendons of the hands; pulmonary edema, excess of thymus tissue, and hyperplasia of the basophils of the hypophysis; antral tumor, or tumor-like proliferation of Schwann cells of the stomach; and pseudomelanosis of the colon.

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GERTRUDE M. ENGBRING, M.D., F.A.C.P.

Guest Editor

We welcome Dr. Gertrude M. Engbring, Guest Editor of the Branch Two, Chicago, issue of the JOURNAL. Following her graduation from the Stritch School of Medicine of Loyola University, she took her internship at Cook County Hospital. There she also held, successively, residencies in obstetrics, medicine, and pathology, and was attending in physical medicine. Later she became attending in physical medicine at St. Joseph Hospital.

Dr. Engbring is now associate professor of medicine and vice-chairman of the department at the Stritch School of Medicine.

Medical Education of Women Has Proved Worth While

IS IT A WASTE OF TIME to give women a medical education? Do they marry and fail to practice medicine? Lowther and Downes[1] studied the careers of 1,240 women who had graduated from Columbia, Cornell, Johns Hopkins, New York University, Yale, University of Pennsylvania, and the Woman's Medical College of Pennsylvania. They found that 82 percent of the married women studied, went into, and remained in full-time practice, and that 90 percent of them engaged in some form of medical activity. Women are needed in medicine as in other professional fields.

A study on women graduating from American medical schools is now being carried out by the Committee on Teaching Institutes and Special Studies of the Association of American Medical Colleges. A preliminary report, based on a small sample of 299 women graduating from medical school between 1925 and 1940, shows that single women spend more time in practice than married women. Most married women, however, remain active in the medical field on at least a part-time basis, even during the years they are rearing children.

The married women in this group have spent 80 percent of the years since they received their medical degrees in part- or full-time practice; the comparable figure for single women is 90 percent. Table I shows the percentage of married and single women who have been employed 90 percent or more, or less than 90 percent of the time.

Table I does not reflect, as the complete study will, the significant non-medical contributions of the married women, such as volunteer services in the public schools, the Red Cross, and other community organizations.

TABLE I
Amount of practice since graduation: part- and full-time practice*
(Preliminary report of AAMC study now in progress)

	Practice 90% or more		Practice less than 90%	
	Number	Percentage	Number	Percentage
Married ...	76	42	106	58
Single	58	70	25	30
Total ...134		51	131	49

*Twenty married women and 14 single women did not answer the question on amount of practice.

A recent study by Birch, Galbraith, and Moon[2] on 151 women who graduated from the University of Illinois during the period 1921-1945, indicated that women physicians "practice a lot of medicine and compare very favorably statistic-wise with a comparable group of men." The major medical fields in which these women practice, listed in order according to the number in each area, are as follows: psychiatry, pediatrics, internal medicine, anesthesia, dermatology, ophthalmology, surgery, pathology, and roentgenology. This order is in agreement with findings of past studies on the areas of specialization preferred by women.

Women physicians have been generally successful. There never has been any serious employment problem among women practicing medicine, even during the depression years . . . The outlook for the future indicates that the supply of women physicians will fall below the demand.

The Woman's Medical College of Pennsylvania, located in Philadelphia, is devoted exclusively to the education of women. In 1954-1955, only six schools estimate that they will not have any women in the freshman class: Chicago Medical, North Dakota, Vanderbilt, West Virginia, Dartmouth, and Jefferson. In the past, all of these with the exception of Dartmouth and Jefferson have admitted women, and the absence of women in the other four schools does not imply a change in policy. It is likely that they received no applications this year from women properly qualified to study medicine. Table II summarizes the estimates supplied by each medical school on the number of women applicants and the number of women students to be admitted this year. Coeducational schools that will admit a high percentage of women this year are: Puerto Rico (14 percent), Howard (12 percent), Wayne (11 percent), Vermont (10 percent), Western Reserve (10 percent), and Wisconsin (10 percent).

For the past 40 to 50 years, the percentage of women admitted to the freshman class has been fairly constant—about 5 percent, and it is estimated that women will constitute about 5.9 percent of the 1954-1955 freshman class.

(This material is reprinted courtesy of *Admission Requirements of American Medical Colleges — 1955*, The Association of American Medical Colleges, Chicago, Illinois, pp. 7-9).

TABLE II. ESTIMATES FOR THE 1954-1955 FRESHMAN CLASS*

Medical School	No. of entering students				Out of State	Foreign	No. of applicants			
	Men	Women		Total			Men	Women		Total
Alabama	75	5	(6%)	80			193	10	(5%)	203
Albany	49	1	(1%)	50	10	1	960	40	(4%)	1000
Arkansas	85	5	(6%)	90			141	6	(4%)	147
Baylor	85	5	(5%)	90	36	4	690	60	(8%)	750
Boston	67	5	(7%)	72	43	1	1091	57	(5%)	1148
Bowman Gray	53	1	(2%)	54	31	2	519	85	(14%)	604
Buffalo	66	4	(5%)	70	11		882	27	(3%)	909
California, L.A.	48	2	(4%)	50	1	1	394	21	(5%)	415
California, S.F.	74	2	(3%)	76	1		414	36	(8%)	450
Chicago Medical	72			72	65		970	30	(3%)	1000
Chicago, Univ. of	67	5	(7%)	72	52	6	950	50	(5%)	1000
Cincinnati	87	3	(3%)	90	63		739	31	(4%)	770
Colorado	74	6	(7%)	80	20		152	10	(6%)	162
Columbia P & S	112	8	(7%)	120	59	3	1394	121	(8%)	1515
Cornell	78	5	(6%)	83	40	1	1236	79	(6%)	1315
Creighton	74	2	(3%)	76	55		752	23	(3%)	775
Dartmouth	24			24	24		396	4	(1%)	400
Duke	72	4	(5%)	76	41	2	656	35	(5%)	691
Einstein (Yeshiva)	Will admit first class in 1955-1956									
Emory	71	1	(1%)	72	38	1	603	19	(3%)	622
Georgetown	119	5	(4%)	124	99	2	924	39	(4%)	963
George Washington	94	6	(6%)	100	90	3	1177	49	(4%)	1226
Georgia	78	2	(3%)	80			214	7	(3%)	221
Hahnemann	103	2	(2%)	105	21		1092	58	(5%)	1150
Harvard	105	9	(8%)	114	90	4	1058	80	(7%)	1138
Howard	66	9	(12%)	75	48	12	465	35	(7%)	500
Illinois	153	13	(8%)	166	2	1	494	37	(7%)	531
Indiana	145	5	(3%)	150	4	1	366	15	(4%)	381
Iowa	114	6	(5%)	120	7	1	161	9	(5%)	170
Jefferson	170			170	36		1826	18	(1%)	1844
Johns Hopkins	68	7	(9%)	75	63	2	425	37	(8%)	462
Kansas	102	6	(6%)	108	10	4	302	6	(2%)	308
Louisiana	115	10	(8%)	125			321	24	(7%)	345
Louisville	92	8	(8%)	100	17	1	204	15	(7%)	219
Marquette	94	6	(6%)	100	60	2	882	18	(2%)	900
Maryland	101	3	(3%)	104	30		361	19	(5%)	380
Medical Evangelist	92	4	(4%)	96	48	8	159	32	(17%)	191
Meharry	60	5	(8%)	65	58	2	528	22	(4%)	550
Miami	71	4	(5%)	75			142	8	(5%)	150
Michigan	192	8	(4%)	200	23	2	527	28	(5%)	555
Minnesota	123	7	(5%)	130	8	2	299	16	(5%)	315
Mississippi	55	1	(1%)	56			148	3	(2%)	151
Missouri	43	1	(2%)	44			132	7	(5%)	139
Nebraska	83	2	(2%)	85	1	2	221	5	(2%)	226
New York Medical	120	9	(7%)	129	55		1706	90	(5%)	1796
New York University	120	10	(8%)	130	29	4	1313	84	(6%)	1397
North Carolina	57	3	(5%)	60	2		236	12	(5%)	248
North Dakota	40			40	4		256	14	(5%)	270
Northwestern	122	6	(5%)	128	86	1	1567	83	(5%)	1650
Ohio	145	5	(3%)	150			989	110	(10%)	1099
Oklahoma	96	4	(4%)	100			193	4	(2%)	197
Oregon	71	4	(5%)	75	12	1	312	20	(6%)	332
Pennsylvania	115	10	(8%)	125	44	1	1615	103	(6%)	1718
Pittsburgh	96	4	(4%)	100	8		628	13	(2%)	641
Puerto Rico	45	7	(14%)	52	2		105	21	(17%)	126

(Table continued following page)

TABLE II. ESTIMATES FOR THE 1954-1955 FRESHMAN CLASS* (Cont.)

	No. of entering students						No. of applicants			
Medical School	Men	Women		Total	Out of State	Foreign	Men	Women		Total
Rochester	68	2	(3%)	70	33		937	49	(5%)	986
Saint Louis	120	5	(4%)	125	77	5	1078	22	(2%)	1100
South Carolina	77	3	(4%)	80			157	3	(2%)	160
South Dakota	31	1	(3%)	32	4		167	7	(4%)	174
So. California	66	3	(5%)	69	7		570	30	(5%)	600
Southwestern	92	8	(8%)	100			395	25	(6%)	420
Stanford	57	5	(8%)	62	5		468	35	(7%)	503
State Univ. NY, NYC	138	12	(8%)	150	13	1	1441	92	(6%)	1533
State Univ. NY, Syracuse	73	3	(4%)	76	5		877	56	(6%)	933
Stritch (Loyola)	85	3	(3%)	88	34	2	733	23	(3%)	756
Temple	126	9	(7%)	135	25	4	1703	35	(2%)	1738
Tennessee	186	14	(7%)	200	79	1	362	23	(6%)	385
Texas	154	8	(5%)	162			451	24	(5%)	475
Tufts	106	4	(4%)	110	48		578	44	(7%)	622
Tulane	126	4	(3%)	130	97	4	972	40	(4%)	1012
Utah	51	4	(7%)	55	13	1	377	8	(2%)	385
Vanderbilt	52			52	36	1	652	27	(4%)	679
Vermont	45	5	(10%)	50	20		294	26	(8%)	320
Virginia Med. College of	81	3	(4%)	84	11		345	18	(5%)	363
Virginia, Univ. of	74	2	(3%)	76	17	3	427	22	(5%)	449
Washington, St. Louis	83	3	(4%)	86	57	1	1361	14	(1%)	1375
Washington, Univ. of	69	6	(8%)	75	10		332	18	(5%)	350
Wayne	89	11	(11%)	100			208	26	(11%)	234
Western Reserve	72	8	(10%)	80	29	2	1023	77	(7%)	1100
West Virginia	31			31			93	3	(3%)	96
Wisconsin	72	8	(10%)	80	3		166	16	(9%)	182
Woman's Medical		50	(100%)	50	33	2		180	(100%)	180
Yale	74	6	(7%)	80	68	1	861	55	(6%)	916
Totals	7,096	445		7,541	2,271	106	51,508	2,883		54,391

*_Admission Requirements—1955,_ The Association of American Medical Colleges, pp. 13 and 14.

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SYMPOSIUM ON CONSTRUCTIVE MEDICINE IN AGING

A one day symposium on "Constructive Medicine in Aging: Predictable Stresses in Middle Life" was held in Cincinnati on December 14, 1954, under the sponsorship of the Wm. S. Merrell Company, as part of its long range program of concentration of research in the field of geriatrics. Nelson M. Gampfer, president and general manager, pointed out that last fall Merrell dedicated a new gerontological laboratory, and its scientists are dedicating themselves to the development of drugs aimed at the chronic diseases of later life.

The symposium fulfilled a four point objective: 1) seminar exploration of fundamental clinico-research problems of gerontology; 2) integration of basic research with practical application to clinical medicine; 3) focusing public and professional attention on the growing problem of aging; and 4) encouraging young professional men to select gerontology as a specialty.

Moderators for the session were: Dr. Marion A. Blankenhorn, director of the department of internal medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio; and Dr. Robert C. Rothenberg, president of the Cincinnati Academy of Medicine, Cincinnati, Ohio.

"Anticipatory medicine is applied foresight," Dr. Edward J. Stieglitz, consultant in geriatrics to Veterans Administration, St. Elizabeth's Hospital, Washington, pointed out in his keynote address. "Its application requires the conscientious and mutual concern of the physician and the patient. If it is sensible for a child to prepare to be an adult, so is it sensible for the 'young' person of 40 to prepare for age . . . Long life in itself is not enough. It is equally important that the later years be lived in health and happiness. For this reason, there is much room for improvement in therapy aimed at preventing or ameliorating the suffering brought on by the chronic diseases of the aging."

Dr. Elmer Hess, of Erie, Pennsylvania, president-elect of the AMA, stated, "There is no male climacteric. Men do not go through a change in anything physiologically or psychologically comparable to woman's experience."

Dr. Paul Starr, professor of medicine, and chairman of the department of medicine, University of Southern California, told his fellow physicians that the production of thyroid and adrenal hormones in the normal old person is not dangerously lower than it is in the younger person. And since these are the hormones which enable an individual to meet stress, it follows that aging men and women have a good chance to meet the problems of old age if they anticipate the invasion of chronic diseases with help from modern therapy.

"Patients with healed myocardial infarction should work," was the recommendation of Dr. William D. Stroud, professor of cardiology, Graduate School of Medicine, Philadelphia. "It is better that the patient fill out his life with rewarding work rather than worried rest," he added.

"Middle age should be counted as somewhere about the 50 year mark," Dr. Lloyd S. Thompson, professor of psychiatry and chairman of the department, Bowman Gray School of Medicine, North Carolina, suggested in his discussion on "Stresses in Middle Life as Seen from the Psychiatrist's Viewpoint." "Society in general fosters a rather dismal outlook for aging," Dr. Thompson said. He urged that life be looked forward to as a whole; that even from childhood the individual be trained to develop in social-emotional maturity, not expecting sharp transitions, but progressing evenly, with acceptance of the difficulties advancing age may entail, and also with realization of the richness which years can confer.

World Health Organization

THE ROLE OF ATOMIC ENERGY in the development of medicine and biology, and the responsibilities of the World Health Organization in this new field, were explored in Geneva December 13 to 16, 1954, at a meeting of four scientists invited by Dr. M. G. Candau, Director-General of the WHO.

The discussions were led by Dr. John Bugher, director of the division of biology and medicine, United States Atomic Energy Commission, Washington, D.C., with the participation of Dr. A. J. Cipriani, director of the division of biology and radiation hazards control, Chalk River, Ontario, Canada; Dr. John F. Loutit, director of the radiobiologic research unit, Atomic Energy Research Establishment, Harwell, England; and Prof. Charles Manneback, professor of physics at Louvain University, Belgium.

The WHO consultants dealt with two main topics: first, problems of health protection in dealing with atomic energy, including the disposal of radioactive waste material, nuclear reactor safety, definition of radiologic units, and standardization of radioactive materials; and second, the constructive use of atomic energy in biology, medicine, and public health.

Discussion of the positive aspects of atomic energy centered on the use of radioactive isotopes in diagnostic procedures, in treatment of diseases, and in medical research. The WHO consultants indicated fields in which the use of radioactive isotopes can lead to important discoveries, among them human biology and the diagnosis, treatment, epidemiology, and control of diseases.

Among other subjects discussed were nutritional problems, the solution of which may be advanced through the use of atomic energy in agriculture and fisheries.

The meeting of consultants was planned some time ago by the WHO, but was given more urgency by a resolution adopted on last December 4 by the United Nations General Assembly, calling for an international conference on the peaceful uses of atomic energy and establishing immediately an advisory committee to prepare this conference. The assembly decided on a conference for the study in general of the development of atomic power and to consider in particular technical areas such as biology, medicine, and radiation protection. The conference is to be held not later than next August.

Competent agencies, among them the World Health Organization, are to be called in consultation by the Advisory Committee and will participate in the conference. The discussions of the WHO consultants represent the first contact with four outstanding experts devoted to the medico-biologic aspects of atomic energy, and should make it possible for the WHO to contribute to the discussions of the Advisory Committee and to participate fully in the actual work of the international conference.

* * *

The World Health Organization must give first priority to the problems of health protection against atomic radiation in its new international program in the field of atomic energy, its Executive Board decided in Geneva, January 20, 1955. The Board took its decision after considering a Japanese proposal calling on WHO to promote research into the effects of radioactivity on human beings.

The organization first recognizes that new atomic energy developments will influence WHO's program deeply, and welcomes the UN General Assembly's invitation to WHO to participate in the international conference on Peaceful Uses of Atomic Energy to be held in Geneva by next August.

Dr. M. G. Candau, WHO Director-General, stressed the need for early planning to avoid public health dangers arising from a new type of industrial development made possible by atomic energy. From the economic standpoint, early action would minimize the cost of preventive measures. The long-term program envisaged by WHO, he said, included protection of people working with radiation, public health protection of the community, collection and dissemination of relevant information, help in training personnel in protection measures, and exchange of scientific information.

Among the health problems cited by Dr. Candau as justifying the priority rating given to the health protection aspects of the program are: radiation-induced diseases needing further study; the potential danger involved in the disposal of radioactive wastes, particularly when a great number of atomic plants are built, with resulting contamination of rivers, air, soil, and sea, and the need for study of the location of reactors in relation to population densities; the potential danger to populations resulting from accidents which are always possible with any type of nuclear reactor; the health problems of uranium mining resulting in carcinogenic (cancer-inducing) effects; problems in the transport of radioactive materials and radioisotopes; and the need for establishment of standards for radioactive materials and units of radioactivity, essential to the accurate measurement of dangerous irradiations.

American Medical Women's Association

PRESIDENT'S MESSAGE

THERE IS NOT MUCH TIME left between now and our Annual Meeting in Atlantic City on June 2 to 5. Knowing the large number of participants at these meetings, I hope you have completed your reservations at the Hotel Dennis before this. Being present will give you a chance to hear, at first hand, the reports of your officers and Committee chairmen.

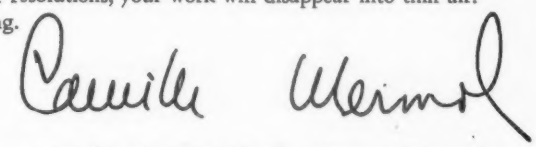
The luncheon on Friday, June 3, will probably be devoted to reports and suggestions from the Branches. On Saturday noon, we will begin to talk about Industrial Medicine, which will be the topic to be discussed by our Association during the year 1955-1956. Since most of us come in contact with some form of industrial medicine frequently, it is a subject which will be of interest to every member of this Association. If there is some particular phase of it which you wish brought out, please let me know at once, so we can incorporate it into the program, if possible.

All Branch presidents, please note this topic and plan to have at least one program concerning it at your meetings next year.

We have had such excellent response concerning the nominations for Medical Women of the Year that this project will be continued next year. Please start now to line up your candidates, so that your selection will be completed next September. We want to look forward to 100 percent representation from the Branches in this important event at our next Mid-Year-Meeting.

I wish to remind all of you who will be presenting reports that just a statement of facts, without conclusions, is of no avail. As a matter of fact, the conclusions and suggestions you make are our guides for future work. Furthermore, if you want the suggestions you have to offer implemented and carried out by the Association, they must be presented in the form of **Resolutions** in writing, to Reference Committee A before the time of the meeting. Without written resolutions, your work will disappear into thin air.

Plan to come and make this a memorable meeting.



P.S. Urgent: If you have not answered the questions regarding the terms of office of your officers, please turn to advertising pages 14-15, and send your answers at once to the AMWA office at 1790 Broadway, Room 409, New York 19, New York.

ANNUAL MEETING
June 2-5, 1955
Hotel Dennis, Atlantic City, N.J.

Thursday, June 2
- 9:00 a.m.—Registration—Lower Lobby
- 9:00 a.m.—Publications Committee — Board Room
- 11:00 a.m.—Finance Committee—Art Studio
- 2:00 p.m.—Executive Committee Meeting — Board Room

Other committee meetings as arranged by the chairmen

Friday, June 3
- 9:00 a.m.—Registration—Lower Lobby
- 9:30 a.m.—Board of Directors—Board Room
- 10:30 a.m.—General Session—Garden Lounge
- 12:30 p.m.—Luncheon—Ozone Suite
- 3:00 p.m.—General Session—Garden Lounge
- 7:30 p.m.—Woolley Memorial Lecture — Ozone Suite

Saturday, June 4
- 9:00 a.m.—Registration—Lower Lobby
- 9:30 a.m.—General Session—Garden Lounge
- 12:30 p.m.—Luncheon—Ozone Suite
- 3:00 p.m.—General Session—Garden Lounge
- 7:30 p.m.—Inaugural Banquet—Ozone Suite

Sunday, June 5
- 9:30 a.m.—Executive Committee Meeting — Board Room
- 10:30 a.m.—Board of Directors Meeting — Board Room

(If you have not already done so, please fill out the following forms: Room Reservations—advertising pages 32-33; Meal Reservations—advertising page 36.)

New Members—1955

CALIFORNIA

Alethea M. Dollinger, M.D.—399 W. Las Tunas Drive, San Gabriel, *Calif. 12, 1939,* Anes

Marianne Hessel, M.D. — 1501 South Catalina, Redondo Beach, *Wisc. 6, 1947,* Pd

Esther E. Vogel, M.D.—1139 North Brand Avenue, Glendale, *Calif. 12, 1939*

Lillian Wong, M.D. — 380 Page, San Francisco, *Minn. 4, 1950,* GP

ILLINOIS

Joanne Decker Denko, M.D.—910 E. 57th Street, Chicago 37, *Md. 7, 1951*

Mary Monica Grigg, M.D.—100 East Jeffery Street, Kankakee, *Buch. 1, 1947*

Florence White Hark, M.D.—822 Clinton Place, River Forest, *Ia. 3, 1922,* Ob

Mary J. Otten, M.D. — 500 E. Monroe Street, Springfield, *Ill. 11, 1948,* ObG

Mimi D. Slominski, M.D. — 1853 W. Polk Street, Chicago, *Ind. 20, 1949,* Path

Julia Shih-fan Yu, M.D. — 707 Fullerton Avenue, Chicago, *China 17, 1948,* Pd

MASSCHUSETTS

Susan Butler, M.D.—1400 Hancock Street, Quincy, *Pa. 7, 1947,* I

NEW JERSEY

Frances L. Steinman, M.D. — 91 Amboy Avenue, Metuchen, Pd

NEW YORK

K. Livingston Klochkoff, M.D.—20 East 74th Street, New York, *N.Y. 6, 1950,* GP

K. Elizabeth Pierce Olmsted, M.D.—568 Lafayette Avenue, Buffalo, *N.Y. 6, 1939,* Oph

Frances Pascher, M.D.—80 Linden Blvd., Brooklyn, *N.Y. 8, 1928,* D

OHIO

Jeanne E. Andrews, M.D.—10515 Carnegie Avenue, Cleveland, *Wisc. 5, 1950,* Pd

Jeanne E. Nitchals, M.D.—2205 Beechmont Avenue, Cincinnati, *O. 41, 1949,* Pd

Emily E. Wright, M.D.—117 Glenridge Place, Cincinnati, *O. 41, 1950,* ObG

PENNSYLVANIA

Lyndall Molthan, M.D.—Valley View Lane, Colonial Village, Wayne, *Pa. 13, 1949,* I

TENNESSEE

Margaret Abrahamson Halle, M.D.—3364 Poplar Avenue, Memphis, *O. 41, 1946,* Oph

TEXAS

Grace K. Jameson, M.D.—112 N. Blvd., Galveston, *Tex. 2, 1949,* NS

VIRGINIA

Shirley T. Swain, M.D. — 3039 N. Peary Street, Arlington, *D.C. 1, 1945,* Pd

WISCONSIN

Mary E. Van Vleet, M.D.—425 E. Wisconsin, Milwaukee, *Ill. 9, 1949,* I

ASSOCIATE MEMBERS

E. Arlene Bledsoe, M.D.—Box 286, Marshfield, Wis.

Margaret R. Dietz, M.D.—Children's Hospital of Michigan, Detroit, Mich.

Hortense M. Gandy, M.D.—Strong Memorial Hospital, Rochester, N.Y.

Elizabeth Gershman, M.D.—720 S. Wolcott St. Chicago, Ill.

Hanna Klaus, M.D. — 630 S. Kingshighway, St. Louis, Mo.

Susanne Elliott Larsh, M.D.—Veterans Administration Research Hospital, 311 E. Huron Street, Chicago, Illinois.

Jean D. Lockhart, M.D.—2941 View Point Road, Alexandria, Va.

Myrna F. Loth, M.D.—5841 S. Maryland Ave., Chicago, Ill.

Nancy Stokes McCall, M.D.—325 Maple St., San Francisco, Calif.

Gwendolyn M. Lutz Morris, M.D.—322 Burnet Ave., Cincinnati, Ohio.

Margaret M. Sedberry, M.D. — 5800 Bull Creek, Austin, Texas

Anne Wight, M.D. — 37 Chestnut Street, Boston, Massachusetts.

JUNIOR MEMBERS

Mary Adeline Hirsh—2334 Steiner St., San Francisco, Calif.

Ann Irish—3155 Berkshire Rd., Cleveland Hts. 18, Ohio

Beverly Carver Morgan — 2200 Vallejo St., San Francisco, Calif.

Ingeborg B. Shaffer—210 Congress St., Brooklyn 1, New York.

Charlotte Graves Tallerday — 357 West 262 St., Riverdale 71, N.Y.

Jacqualine S. Thomas—615 Howard Pl., Madison, Wisconsin.

Nancy J. Wing—St. Luke's Hospital, Richmond, Virginia.

University of Illinois

Olga M. Jonasson—5846 N. Spaulding, Chicago 45, Illinois.

Josette Woël—818 South Wolcott St., Box 832, Chicago 12, Ill.

Louisiana State University

Mary Frances Giordano—Box 378, Louisiana State University School of Medicine, 1542 Tulane Ave., New Orleans, La.

Ethel Elizabeth Haas — 768 Claiborne Towers, Madisonville, La.

Bobbie Jean Vining—Box 209, Louisiana State University Medical School, New Orleans, La.

Paula Allen Walden—5424 Camp St., New Orleans, Louisiana.

Northwestern University

Phyllis Lola Bailey — 710 North Lake Shore Dr., Chicago 11, Ill.

Margaret Mary Raycraft — 1439 Keystone Ave., River Forest, Ill.

University of Oklahoma

Joe Rae Hooper—809 N.E. 16th St., Oklahoma City, Oklahoma.

Sylvia Stakle—809 N.E. 16th St., Oklahoma City, Oklahoma.

University of Southern California

Karin Jane Ehrenclou—1737 Kaweah Dr., Pasadena 2, Calif.

Barbara Mae Evans—1945 Lansdowne Ave., Los Angeles 32, Calif.

Gloriat Hern—1201 W. 61st St., Los Angeles, Calif.

Jane Kilgore Jeffreys—634 W. 34th St., Los Angeles 7, Calif.

Woman's Medical College of Pennsylvania

Helen S. Emerson—2807 W. Queen Lane Ave., Philadelphia 29, Pa.

Mildred Faye Greenberg — c/o Woman's Medical College, Philadelphia 29, Pa.

Marie Hren—2811 W. Queen Lane, Philadelphia 29, Pa.

Helen M. Kansas—3339 Indian Queen Lane, Philadelphia 29, Pa.

Charlotte Sokol—3005 Midvale Ave., Philadelphia 29, Pa.

Lila Stein—1725 N. 33rd St., Philadelphia, Pa.

(Elizabeth) Anne Watkins—7511 Wellington St., San Diego 11, Calif.

Dorothy A. Wludyka—3518 Ainslie St., Philadelphia 29, Pa.

Tema G. Wollison—519 King St., Philadelphia 44, Pennsylvania.

Ruth Betty Zak—Woman's Medical College of Pa., 3300 Henry Ave., Philadelphia, Pa.

Yale University

Pauline F. Bucknell—333 Cedar St., New Haven, Connecticut.

Rosalie Annette Burns—Yale University School of Medicine, New Haven, Conn.

NEWS FROM THE BRANCHES

Branch Four, New Jersey

Professional and women's organizations have been invited by Branch Four to an open meeting on Constructive Uses of Atomic Energy, Sunday, March 27, at 2:15 p.m., in the Academy of Medicine in Newark. The speaker will be Brig. Gen. Elbert DeCoursey, director of the Armed Forces Institute of Pathology.

NEW YORK INFIRMARY ALUMNAE

All alumnae of the New York Infirmary are requested to contact the Secretary, Dr. E. Catherine Cline, New York Infirmary, 321 East 15th St., New York, N.Y.

PICTURE CREDIT
Page 96—Courtesy of Bachrach, Boston.

THESE WERE THE FIRST

Dr. Elizabeth Crosby, professor of anatomy at the University of Michigan Medical School in 1939 to 1949, was invited by the University of Aberdeen, Scotland, to organize the first course in histology and neuroanatomy there. In 1950, Dr. Crosby received the annual achievement award of the American Association of University Women.

Dr. May Thorne obtained her medical degree in Brussels in 1895. She was appointed teacher in vaccination at the London School of Medicine for Women. In World War I she was medical adviser to a group of women serving at Malta where she went as a volunteer. She received the rank of captain in the Royal Army Medical Corps and in 1921 retired to devote her efforts to the Royal Free Hospital of London, the pioneer hospital for the medical education of women. Dr. Thorne's mother, Isabel Thorne, was one of the famous "seven" who, with Sophia Jex-Blake, made the historic attempt to enter the medical profession. Her father, Dr. Joseph Thorne, helped to secure the admittance of women students to the Royal Free Hospital where one of the wards now bears the name of May Thorne. Dr. Thorne in 1908 succeeded her mother as honorary secretary of the London School of Medicine for Women and held the same position from 1935 to 1947, in the Royal Free Hospital.

Dr. Marion Gilchrist, born in Rothwell, Scotland, attended classes at the Glasgow school, but not until 1882 did that university examine women students. In 1894, Dr. Gilchrist received her degree in medicine, the first woman in Scotland to graduate in medicine. For 29 years she was assistant ophthalmic surgeon at the Victoria Infirmary, Glasgow, and during World War I she carried out singlehanded the work of the eye department in the infirmary.

Dr. Helen Ryan was the first woman to graduate in medicine from Queen's University, Kingston, Ontario, in 1860. She practiced for many years in Sudbury, Ontario, and retired in 1907. Dr. Ryan was the mother of five children.

—Elizabeth Bass, M.D.

Opportunities For Women in Medicine

CIVIL SERVICE

The U. S. Civil Service Commission has announced that applications are now being accepted for Medical Officer for filling the following trainee positions in St. Elizabeth's Hospital in Washington, D. C.: rotating intern, $2,800 a year, and resident-in-training in psychiatry and in neurology, $3,400 to $4,200 a year. Appointments will be open July 1, 1955.

Applicants for the intern positons must be fourth year students in an approved medical school. For the resident positions, applicants must be graduates from an approved medical school with the degree of doctor of medicine, and in addition must have completed a full year's internship or now be serving such internship. No written test is required. The age limit of 35 years will be waived for persons entitled to veteran preference. Full details concerning the requirements is given in examination announcement No. 429 (B).

Applications will be accepted until further notice by the Board of Civil Service Examiners, St. Elizabeth's Hospital, Washington 20, D.C. Further information and application forms may be obtained from most post offices or from the U. S. Civil Service Commission, Washington 25, D. C.

PUBLIC HEALTH SERVICE

A major expansion and reorganization of the Commissioned Reserve of the Public Health Service, Department of Health, Education, and Welfare, as a national defense measure has been announced by Surgeon General Leonard A. Scheele. The Service expects to commission an additional 2,000 reserve officers by June 30, 1955, and present plans call for the commissioning of another 3,000 officers during the 1955-1956 fiscal year.

The Service has been assigned extensive new defense responsibilities as the result of a delegation by the Federal Civil Defense Administration to the Department of Health, Education, and Welfare recently approved by the President. In addition to building up the Commissioned Reserve to emergency strength, the Service is stepping up research in disaster health problems and is developing a program to reinforce state and local health departments in time of national crisis.

In strengthening the Commissioned Reserve, the Service has two fundamental objectives: 1) Effective emergency utilization of professional personnel with training and experience in public health and 2) augmenting these forces with physicians and other professional people not normally working in the field of public health.

Dr. Scheele said that an officer of the emergency reserve would be called to active duty without his consent only in the event of a national emergency publicly recognized as requiring such action, and that an officer of the emergency reserve already performing important health functions would not be called for service in another area unless the situation in that area clearly justified it. Officers in the emergency reserve may request active duty at any time and will be considered for any available assignments.

The emphasis initially will be on the commissioning of physicians, dentists, sanitary engineers, and nurses, the Service said.

In the near future, the Public Health Service expects to start training officers of the emergency reserve in the health problems associated with atomic, biologic, and chemical warfare and other national emergencies. As the expansion goes forward, the Service hopes to train all reserve officers who can arrange to be away from their regular work for brief periods.

TRAINING IN CHILD PSYCHIATRY

Specialized training in child psychiatry is available in a number of member clinics of The American Association of Psychiatric Clinics for Children which have been approved as training centers by the Association. The training begins at a third year, postgraduate level with minimum prerequisites of graduation from an approved medical school, an approved general or rotating internship, and a two year residency in psychiatry, approved by the American Board of Psychiatry and Neurology. The majority of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

This training is in preparation for specialization in child psychiatry, and especially for positions in community clinics devoted wholly or in part to the outpatient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Most of the clinics have a two year training period although a few will consider giving one year training in special cases.

Fellowship stipends are usually in line with U. S.

Public Health Service standards, that is, approximately $3,600 as these stipends come mainly from the Public Health Service. Stipends sometimes are paid by state departments of mental health, the individual clinics, and occasionally in part by communities. A limited number of training centers can offer higher stipends.

The office of The American Association of Psychiatric Clinics for Children acts as a clearinghouse for applicants. Application may be made through this office or directly to the individual clinics. In all cases, acceptance of applicants for training is by the individual training centers.

For further information and for application forms, write to: Miss Marion A. Wagner, Administrative Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, New York.

RESEARCH GRANTS-IN-AID

The division of medical sciences, National Academy of Sciences, National Research Council, is accepting applications for grants-in-aid of research in these specialized fields:

1. The committee on problems of alcohol has available a limited fund for the support of grants. The committee is interested in fostering research, primarily on the physiologic, biochemical, and pharmacologic effects of alcohol. Applications for the fiscal year 1956-1957 should be postmarked not later than Jan. 15, 1956.

2. The committee on drug addiction and narcotics may have available for the coming year limited resources for the support of research in the fields of analgesia and addiction. The committee also invites information on basic research being carried on in these fields, in order that it may extend its activities as a center for the exchange of information on current investigations in this area.

Details may be obtained by writing to the appropriate committee of the Division of Medical Sciences, National Academy of Sciences, National Research Council, 2101 Constitution Ave., N.W., Washington 25, D.C.

INTERNATIONAL COLLEGE OF SURGEONS

Through the generosity of the Woman's Auxiliary of the United States and Canadian sections of the International College of Surgeons, the College is offering a scholarship to a young Canadian or American surgeon who wishes to study abroad. This scholarship will be in the amount of $3,000 to pay for transportation and living expenses for a period of twelve months. This is not a traveling fellowship. The doctor selected will be expected to spend at least ten months of the year as a resident or Fellow in a teaching center in one of the countries of Europe or South America.

Also through the generosity of the Woman's Auxiliary, the College is able to invite two residents or Fellows in training as surgeons to attend its annual meeting and present before the assembly a suitably prepared clinical or scientific paper. The College will provide transportation and living expenses during the time of the meeting not to exceed the amount of $300, compensation to be based on the distance which must be traveled. The meeting for 1955 is being held in Philadelphia, Pennsylvania, September 12 through 15, 1955.

For further information concerning the above write: The Scholarship Committee, International College of Surgeons, 1516 Lake Shore Drive, Chicago, Illinois.

SCHOLARSHIPS

The Connecticut State Medical Society offers annually a number of scholarships of $500 each to students who are in their final year in an approved medical school in the United States or Canada and whose homes are in the state of Connecticut. Information concerning these scholarships and application forms, which must be submitted before Nov. 15, may be obtained from Dr. Creighton Barker, Executive Secretary, Connecticut State Medical Society, 160 St. Ronan St., New Haven.

* * *

The Summer School of Alcohol Studies of the Laboratory of Applied Physiology, Yale University, will hold its thirteenth annual session in 1955. The regular session will be held during the four week period June 27 to July 22 inclusive. The school, through a series of lectures and seminars, offers a systematic investigation of various aspects of the functions and problems of alcohol as they affect the individual and society. A survey of current medical and psychiatric practice in the care of the alcoholic patient is offered to a limited number of physicians. A limited number of scholarships is granted annually. For further information write: Registrar, Summer School of Alcohol Studies, 52 Hillhouse Avenue, Yale Station, New Haven, Connecticut.

* * *

Several partial scholarships of $500 each will be sponsored by the American Medical Writers' Association for use at the University of Illinois, Urbana, and the University of Missouri, Columbia, to be applied toward the first four year collegiate course leading to a bachelor's degree in medical journalism being inaugurated next September at these schools. Descriptive literature concerning the

academic courses may be obtained by writing to Earl F. English, Ph.D., dean, School of Journalism, University of Missouri, Columbia, and I. W. Cole, School of Journalism and Communications, University of Illinois, Urbana.

AWARDS

Six awards for graduate study in Italy are open to men and women candidates in any field. Each grant covers a stipend of 600,000 lire (approximately $970), payable in three installments. Free tuition will be provided for an entire academic year; the minimum period of study is six months. For travel within Italy, 10,000 lire will also be provided. Partial travel funds may be available between the United States and Italy. Applicants must present proof of a Master's degree, or the equivalent in advanced work, such as recognition as a scholar, or a scientist. This competition is not open to recent B.A. graduates who have had no further work or study. Applicants must also present a detailed program for advanced study or research. Closing date, April 1, 1955. These are offered by the Italian Government.

* * *

The American Congress of Physical Medicine and Rehabilitation will award annually a prize for an essay on any subject relating to physical medicine and rehabilitation. The contest, open to anyone, is directed primarily to medical students, interns, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation. Manuscripts must not exceed 3,000 words (exclusive of headings, references, legends for cuts, tables, and so forth) and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted and it must not have been published previously. Manuscripts must be in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Avenue, Chicago 2, Ill., not later than June 1, 1955.

The winner will receive a cash award of $200, a gold medal properly engraved, a certificate of award, and an invitation to present the contribution at the thirty-third annual session of the organization in Detroit from August 28 to September 2, 1955. All manuscripts will be returned as soon as possible after the name of the winner is announced.

* * *

The Philadelphia Diabetic Society has announced the establishment of an annual trophy and cash award to promote independent medical research by physicians, medical students, and research workers in the Philadelphia area. The new Nathaniel N. Wolfsohn award offers yearly prizes of $500 and a gold plaque, and $200 and a silver plaque, to authors of the best original papers on subjects related to the causes and treatment of diabetes mellitus. Deadline for submission of papers in the current year's judging is April 1, 1955; presentation of awards will be made during the annual May meeting of the Philadelphia Diabetic Society.

* * *

At the meeting of its board of directors Oct. 14, the Iowa Tuberculosis and Health Association established an award in the name of Dr. Walter L. Bierring, Des Moines, a charter member and in 1917 president of the association.

The award will be given to a person who has contributed to the control of tuberculosis or chest diseases in Iowa.

LEGAL MEDICINE CENTER ESTABLISHED

Western Reserve University and the office of Dr. Samuel R. Gerber, coroner of Cuyahoga County, have established a training and research center for lawyers, physicians, law enforcement officers, and others involved in protecting the public welfare. In addition to Western Reserve School of Medicine, the Western Reserve law school, and the county coroner's laboratory, the facilities include those of the Case Institute of Technology, and the Institute of Pathology, all located at University Circle on Cleveland's east side. Two preliminary courses, "Medical Aspects of Civil Litigation" and "Scientific Proof in Criminal Cases," were presented at the school of law during the last year.

COURSE

The University of Colorado Medical Center and the Colorado State Society of Medical Technology will sponsor a postgraduate course in medical technology at the center, 4200 E. 9th Ave., Denver, March 16 to 19, 1955. Registration fee is $12.50 for the entire course; $6 for a single day. The principal guest speakers will be Dr. Thomas Hale Ham, Western Reserve University School of Medicine, Cleveland, and Dr. Mervin H. Grossman, director of laboratories, St. Paul's Hospital, Dallas, Texas. Information may be had from the Office of Graduate and Postgraduate Medical Education, 4200 E. 9th Ave., Denver 20, Colorado.

RESIDENCY WANTED

A residency in pediatrics is wanted by a Korean woman doctor, who is available now. Send information to: Dr. Ada Chree Reid, 118 Riverside Drive, New York 24, New York.

MARY PUTNAM JACOBI FELLOWSHIP

The Women's Medical Association of New York City offers the Mary Putnam Jacobi Fellowship to a graduate woman physician, either American or foreign. This fellowship grant of $1,000, starting October 1, is given for medical research, clinical investigation or postgraduate study limited to a special field of medicine. Five hundred dollars are available October first and the second $500 following at the end of the fourth month. There is also the possibility of a third $500 award if the committee judges the work done to be of special merit.

Applications for this fellowship must be filed with the secretary of the committee before May 1 and will be acted on by June 1. Applications must be accompanied by 1) a statement from a physician of a recent physical examination, 2) transcripts of her college and medical school records, 3) personal letters of recommendation from two or more physicians under whom she has studied, 4) a statement by the applicant of the problems she proposes to investigate or studies she will undertake, 5) a statement from the person under whom she proposes to study of his or her interest in her project, and 6) a recent photograph with her age. All the above data must be at hand before the application will be considered.

The recipient of the fellowship will be expected to give her full time to this study, and to make reports to the committee at four month intervals with a view to publication at the end of her fellowship project.

Application blanks may be obtained from the secretary of the committee.

ELISE S. L'ESPERANCE, M.D., *Chairman*
Mary Putnam Jacobi Fellowship Committee
ADA CHREE REID, M.D., *Secretary*
118 Riverside Drive, New York 24, N.Y.

FELLOWSHIPS

The Hematology Research Foundation announces the Ruth Berger Reader fellowships. Fellowships usually amount to $1,500. The foundation, which originated in 1943 with a membership of 45 women, now has more than 1,000 members. Fellowships and grants are awarded annually, usually in July, by the medical advisory board. Application forms are available in April or May from the Foundation's office, 64 W. Randolph St., Chicago 1, Illinois.

* * *

Fellowships in hematology will be available for appointment July 1, 1955, at Stanford University Hospitals and the Veterans Administration Hospital, San Francisco. These fellowships carry a stipend with appointment and are subject to renewal for the following year. They will be served under Dr. Byron E. Hall and Dr. Forrest M. Willett, chief of medicine at the Fort Miley Veterans Administration Hospital. A fellowship in cardiology is also available at the hospital under the auspices of the San Mateo County Heart Association. This fellowship carries a stipend with appointment and is subject to renewal for the following year. It will be served under Dr. Arthur Selzer and Dr. Willett.

* * *

Applications for U. S. Atomic Energy Commission fellowships in radiological physics and industrial hygiene for the 1955-1956 school year are being received by the Oak Ridge Institute of Nuclear Studies. The Industrial Hygiene Fellowships Program supports persons studying for the Master's degree in this field at either the Harvard School of Public Health, Boston, or the University of Pittsburgh Graduate School of Public Health. Radiological physics fellowships are carried out in three separate programs as follows: at Vanderbilt University, Nashville, Tenn., and Oak Ridge, (Tenn.) National Laboratory; at the University of Rochester (N.Y.) and Brookhaven National Laboratory, Upton, Long Island, N.Y.; and at the University of Washington and the Hanford Works. In each case, nine months of course work at the university are followed by three months of additional study and field training at the co-operating AEC installation. Up to 25 Fellows may be appointed in each of the three programs, and course work may be applied toward an advanced degree. Six month extensions may be granted in some cases for completion of work on the Master's degree.

Basic stipend for both fellowships is $1,600, with an allowance of $350 for a spouse and $350 for each dependent child. Tuition and laboratory fees are paid as a part of the fellowship. Industrial hygiene Fellows may receive an additional allowance of $200 if they have already completed a year of graduate study or have appropriate work experience. Information may be obtained from the Fellowship Office, University Relations Division, Oak Ridge Institute of Nuclear Studies, P.O. Box 117, Oak Ridge, Tennessee.

OFFICE FOR RENT

West Bronx building, large corner, professional, modern, five room office. Present doctor being drafted. Reasonable rent. Call CY 5-0460, 10:00 to 4:00, or write: Real Estate, 2129 Valentine Ave., Bronx 57, New York.

M. ALICE PHILLIPS, M.D.

When Alice Phillips was named as chairman of the department of obstetrics and gynecology at the New England Hospital in Boston in September 1954, and a review of her life was requested, I recalled her many allusions to Charleston, Illinois, in the 35 years of my friendship with her.

It would be foreign to me not to look into the case history, to find out, if possible, what factors operated to develop the girl who went to district school in Coles County, Illinois; the poised and skillful surgeon; the trusted consultant for her medical confreres; and the choice of medical women in Chicago when capability and responsibility were prerequisites for an assignment. If my analysis of her life is correct, the character and teaching of Livingston C. Lord of Eastern State College at Charleston left an impact upon her sensitive, bright, and logical mind in its most receptive period, and left an indelible imprint upon her character.

The facts of Alice Phillip's life are not, in themselves, striking or unusual. She was born into a family of nine children at Sullivan, Illinois. Her father, a successful farmer, possessed a practical and realistic attitude toward his work. He was ambitious and generous to his children. All of them were sent to the University of Illinois, where most of them graduated. Her mother was also of a practical turn of mind. From her mother, Dr. Phillips received, in addition to a resolute spirit, a flair for art. Together with an interest in history and politics, art has been her recreation.

After graduating from the University of Illinois in 1917, having majored in home economics, she took a course in hospital dietetics in order to be eligible for war work. Instead of entering army service, she took a position as research assistant to Louis Baumann at the University of Iowa. After a year in research, she decided to enter medicine, and so enrolled at Rush Medical College in the fall of 1919. She graduated from Rush, took her rotating internship at North Chicago Hospital, spent a year as school physician at Normal, Illinois, went to Vienna to study for six months, and then returned to Chicago to train in obstetrics at the Chicago Lying-In-Hospital. Obstetrics proved her forte and, after two years as assistant to Dr. D. A. Horner, she entered the private practice of obstetrics and gynecology in Chicago. In addition to carrying on her own practice, she acted as consultant to the Student Health Service at the University of Chicago for 19 years. For ten years she was consultant in gynecology at the Douglas Smith Fund and, for five years was director of this organization. Although obstetrics was her first love, her work in gynecology led her, naturally enough, to cancer prevention. For nine years she consulted at the Cancer Prevention Center, learning to read Papanicolaou slides several years before most of us knew of their value. At the time of her appointment to the New England Hospital, she was associate on the staff of Chicago Lying-In-Hospital and chairman of the staff of obstetrics and gynecology at Women and Children's Hospital, Chicago. Her education at Rush and Chicago Lying-In-Hospital cannot be minimized. She could scarcely have achieved her professional excellence without it.

Nevertheless, the impetus and inspiration for her work did not stem from the "big name" schools which she attended, but from the school in Charleston where, in her early teens, she came under the influence of a great teacher who had strength, vision, and integrity of character.

—Ruth E. Taylor, M.D.

News of Women in Medicine

DISTRICT OF COLUMBIA. A conference on yellow fever was held in Washington recently. It was called by Dr. Fred L. Soper, director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization. One of the participants in the conference was DR. RUTH R. PUFFER, chief of epidemiology and statistics of the Pan American Sanitary Bureau.

"The Challenge of Good Medical Care" is the title of a radio series presented by the George Washington University over radio stations WGMS. On January 29, the program was a panel discussion on "Rehabilitation." The chairman was DR. IRENE TAMAGNA, director of George Washington University Hospital's medical integration and rehabilitation unit.

DR. CHIRAPAN SUKANNHAKETY of Bangkok, Thailand, is resident in anesthesiology at George Washington University Hospital.

Recently a new arthritis research laboratory was opened at George Washington University. Associated with the work of the new laboratory is DR. RUTH H. WICHELHAUSEN, assistant professor of medicine at the University, and chief of arthritis research at Mount Alto Veterans Administration Hospital.

OHIO. DR. JANICE A. MENDOLSOHN, director of medical and surgical services at the Dayton State and Receiving Hospital, presented a paper on "Rehabilitative Physical Therapy in Neuropsychiatric Patients" at a meeting of the Physical Therapy Association, held recently at the hospital.

The National Vitamin Foundation has awarded a grant of $4,000 to DR. IRENE T. KLINE of Western Reserve University, Cleveland, for studies of pantothenic acid in the biosynthesis of steroids.

General

DR. DELILAH RIEMER and others of Bedford, Massachusetts, were awarded a bronze medal for the exhibit on "Rehabilitation of the Psychiatric Patient." The award was presented by the American Congress of Physical Medicine and Rehabilitation at the thirty-second annual scientific and clinical session. At the meeting, DR. FRANCES BAKER of San Mateo, California was elected secretary of the Congress.

DR. EMMA S. MOSS, co-author, with Mr. Albert L. McQuown, of "Medical Mycology" (Williams & Wilkins), was chosen president-elect of the American Society of Clinical Pathologists at the recent international pathology meeting in Washington, D.C. At the same meeting, Dr. Moss served as moderator for a symposium on fungus diseases.

Dr. Moss and Mr. McQuown received the Billings gold medal for correlation and presentation of facts for their scientific exhibit at the American Medical Association convention in San Francisco in June.

International

Great Britain. DR. GRACE EGGLETON has received the title of reader in physiology in respect of her appointment at London University College.

Two hundred members and guests attended the subscription dinner arranged by the London association for the council of the British Federation of Medical Women on November 12, 1954. It was held in the Great Hall of the Royal College of Surgeons. The guests were received by MISS GWENDOLINE SMITH, president of the London association, jointly with DR. ANNIS GILLIE, the Federation's president. Dr. Angus Macrae spoke with sincerity and wit about three modern medical women with whom he had day-to-day contact. Dr. Gillie in reply, however, harked back to the beginnings of organized medical women, to the Association of Registered Medical Women, the forerunner of the present Federation. At the first dinner, held in 1880 at the "Trafalgar," Greenwich, there had been only nine diners, she said, but they formed a most distinguished company.

Germany. DR. ELISABETH GERHARTZ, medical director of the refugee centers of Berlin, received a facilitation grant for the International Educational Exchange Service of the U. S. Department of State covering international travel only. Her visit was planned in response to the request of many American women leaders who wanted Americans to learn the problems Berlin faces. At the present time one of Dr. Gerhartz's daughters, DR. MARIA HENKE, is a resident physician at Bellevue Hospital, New York.

Book Notices

EDITOR'S NOTE: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

GLANDULAR PHYSIOLOGY AND THERAPY. Prepared under the Auspices of the Council on Pharmacy and Chemistry of the American Medical Association. Fifth Edition, Completely Revised and Rewritten. Pp. 596. Price $10.00. J. B. Lippincott Company, Philadelphia, 1954.

In the 30 years since this book was first published, such tremendous advances have been made in the field of endocrinology that it is now a full-fledged medical science in its own right. The enormous amount of research work upon which this book is based is shown by the extensive reference lists following each section. The various endocrine systems are discussed individually, not only from the standpoint of anatomy, physiology, and abnormality of function, but also treatment is given adequate emphasis. Of equal importance is the fact that the limitation of treatment is stressed. There is an excellent diagram showing the correlation between the hormonal systems.

The 31 contributors are among the foremost clinicians and research workers in the field, and together they have succeeded in compiling a completely revised text, as those who have used the last edition of 12 years ago will find. One section of the book deals with the endocrine management of malignant disease and another with common misconceptions in endocrine therapy. This latter is the most interesting, and, incidentally, the most practical section in the book.

This book is especially recommended to the physician interested in metabolic and endocrine diseases, but the gynecologist and general practitioner will also find it very useful.

—George A. Hess, M.D.

PROCEEDINGS OF THE SECOND NATIONAL CANCER CONFERENCE (Two Volumes). American Cancer Society, Inc., National Cancer Institute of the U.S. Public Health Service and American Association for Cancer Research. Cincinnati, Ohio, March 3, 4, 5, 1952. Pp. 1,687, illustrated. Price $7.50. The American Cancer Society, New York, 1954.

The Second National Conference on Cancer was characterized by enthusiasm and guarded optimism, and sparkled with the names of luminaries in the many medical and scientific fields which deal directly or indirectly with cancer.

In the general sessions, individual speakers covered nine broad topics, such as "Viruses and the Cancer Problem," "Clinical Cancer Chemotherapy," and "Radiation Therapy in Cancer." Two round-table discussions, one dealing with the problems of analyzing statistics on breast cancer therapy, and the other covering the steroid-related tumors (breast, genitourinary, and female genital tract) brought together many serious and experienced minds. It was the opinion of the panel on breast that faulty analyses resulted in faulty and conflicting conclusions regarding the effectiveness of various programs of therapy for breast cancer.

Panel meetings occupied the major portion of the Conference, and concerned Breast, Genitourinary, Head and Neck, Lymphoma-Leukemia, Female Genital Tract, Gastrointestinal Tract, Lung, Radiobiology, Genetics, Cytology, Chemotherapy, Virology, Steroids, and Isotopes. Some high lights of these conferences included Urban's presentation of internal mammary node dissection for Stages I and II breast cancer; reports on the use of radioactive cobalt, and the betatron; and statistics linking tobacco and lung cancer.

The collected papers are a valuable reservoir of information for all who deal with the cancer problem; their use for quick reference is limited by the lack of co-ordinated summarization, although a good cross index has been provided.

—Margaret H. Edwards, M.D.

DISEASES OF THE SKIN For Practitioners and Students. By George Clinton Andrews, M.D., F.A.C.P., Clinical Professor of Dermatology, the College of Physicians and Surgeons, Columbia University; Attending Dermatologist to the Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York. Pp. 877, with 777 illustrations. Price $13.00. W. B. Saunders Company, Philadelphia, 1954.

The new edition of this textbook should be welcomed by the practitioner and student of dermatology whose needs it is admirably designed to fill.

Its scope is comprehensive; obsolete material has been eliminated and evidence of revision and careful editing is apparent throughout the book. The reference material cited is pertinent and includes an excellent coverage of current literature. Description and evaluation of diagnostic and prognostic tests such as the Tzanck test for bullous dermatoses; the Treponema immobilization test; the L.E. phenomenon; and the skin tests for leprosy, sarcoidosis, and fungus diseases provide accurate and useful information.

The sections on therapy have been revised extensively to include discussion of the antibiotic and chemotherapeutic agents introduced during the past five years. Material on lupus erythematosus, scleroderma, dermatomyositis, and periarteritis nodosa has been rearranged and largely rewritten in accordance with recent changes in the concept of these diseases, and the newer therapeutic approach with quinacrine, chloroquine, and the steroids is included. Sulfone therapy and the use of prophylactic BCG injections in leprosy, the use of the isonicotinic acid derivatives in the tuberculoderms, and steroid therapy of pemphigus and other less serious dermatoses is covered adequately.

Illustrations have been reduced in number, but generally improved in quality. The index is carefully arranged and most complete. The style is lucid and, as in previous editions, affords easy comprehension.

—Margaret Gray, M.D.

Current Publications OF MEDICAL WOMEN

Ferrer, M. Irené, and **Harvey, Réjane M.:** The etiology of secondary pulmonary hypertension. Bull.New York Acad.Med. **30:** 208-220, Mar. 1954.

Leone, Rita: Importanza della componente batterica nella genesi delle ulcere tardive su cute X. Minerva dermat. **28:** 215-221, Sept. 1953. English summary p. 220-221.

Chatterjee, Asima: Rauwolfia alkaloids. Fortschr.Chem. organ.Naturstoffe **10:** 390-422, 1953.

Barber, L. M., Mazzadi, L., and **Reese, Clare N.:** Carbohydrate disturbance due to isonicotinic acid hydrazide. Tuberculology **13:** 111-114, Sept. 1953.

Leyva, F. R., and **Sowers, Muriel:** The use of ACTH and cortisone in the nephrotic syndrome in children. Clin. Proc.Child.Hosp. **9:** 262-265, Dec. 1953.

Jongco, Artemio P., and **Pesigan, Naida E.:** Cor pulmonale in children. Acta med.philippina **9:** 229-240, Jan.-Mar. 1953.

Graeber, M.P., Brown, G. C., Pillsbury, Ruth M., and others: Group therapy on an acute service. Am.J. Psychiat. **110:** 677-680, Mar. 1954.

Stewart, Ann H., Weiland, I. H., **Leider, A. R.,** and others: Excessive infant crying (colic) in relation to parent behavior. Am.J.Psychiat. **110:** 687-694, Mar. 1954.

Ostrum, Herman W., Durant, T. M., and **Dufner, Mary E.:** Clinical pathological conference. Am.J.M.Sc. **227:** 319-325, Mar. 1954.

de la Torre, J., and **Faz, Alicia:** Peritonitis del recien nacido. Rev.mex.pediat. **22:** 69-78, May-June 1953.

Ana-Horrilleno, Estrella Sta.: Cytology of nasal smears among allergic Filipinos. Acta med.philippina **9:** 197-204, Jan.-Mar. 1953.

Potter, Edith L., and Shapiro, S.: Survey of opinions of obstetricians concerning official reporting of fetal mortality. Am.J.Obst.&Gynec. **67:** 651-660, Mar. 1954.

Jones, Georgeanna S., and Smith F.: Treatment of the dysmenorrhea symptom complex. A preliminary report on the efficacy of a uterine "relaxing factor." Am.J.Obst.&Gynec. **67:** 628-633, Mar. 1954.

Dimsdale, Helen: The infantile cerebral palsies. M. Press **231:** 206-210, Mar. 3, 1954.

Hellerstein, Herman K., and **Goldston, Elaine:** Rehabilitation of patients with heart disease. Postgrad. Med. **15:** 265-278, Mar. 1954.

Harvey, Réjane M., and **Ferrer, M. Irené:** Pulmonary circulation: its relation to normal and altered dynamics. Dis.Chest **25:** 247-252, Mar. 1954.

Woodbridge, Helen McFarland: A study of a biopsy service: problems in diagnosis of 1,283 cases. Oral Surg. **7:** 297-306, Mar. 1954.

van Wetter, Andrea: Un nuovo farmaco inibitore e riequilibratore della costellazione diencefalo ipofisaria: la diacetil-corynanthine. Endocrinol.e sc.costit. **21:** 239-179, [1953]. English summary p. 276.

Lattes, R., McDonald, J. J., and **Sproul, Edith:** Nonchromaffin paraganglioma of carotid body and orbit. Ann.Surg. **139:** 382-384, Mar. 1954.

Straight, Belinda: Schizophrenic-like psychoses in children. Clin.Proc.Child.Hosp. **10:** 6-16, Jan. 1954.

Halpert, Béla, Fields, W. S., and **De Bakey, M. E.:** Intracranial metastasis from carcinoma of the lung. Surgery **35:** 346-349, Mar. 1954.

Evans, Mary E.: The low salt syndrome in children during hot weather. J.Kansas M.Soc. **55:** 125-129, Mar. 1954.

Young, J. M., Jones, Elise, Hughes, Felix A., and others: Endobronchial hamartoma. J.Thoracic Surg. **27:** 300-305, Mar. 1954.

Crutcher, Richard R., and **Plott, Carol L.:** Mediastinal lipoma: the successful removal of an eight pound, one ounce (3,657 grams) tumor. J.Thoracic Surg. **27:** 261-265, Mar. 1954.

Shaw, E. B., and **Levin, Marcia:** The infrequent incidence of nonparalytic poliomyelitis. J.Pediat. **44:** 237-243, Mar. 1954.

Disenhouse, R. B., Anderson, R. C., Adams, P., Jr., Novick, Rosalind, and others: Atrial septal defect in infants and children. J.Pediat. **44:** 269-289, Mar. 1954.

Pennoyer, Mirriam M., and **Sullivan, Margaret P.:** Skin care of the newborn infant. J.Pediat. **44:** 258-263, Mar. 1954.

McCue, Carolyn Moore: A follow-up study of suspected rheumatic fever patients. J.Pediat. **44:** 290-293, Mar. 1954.

Bacon, Catherine L.: Psychoanalytic observations on cardiac pain. Psychoanalyt. Quart. **23:** 7-19, Jan. 1954.

Jaeger-Lee, Dorothy S., Knop, Catherine I., and **Sartwell, Mary K.:** Effect of L(+) glutamic acid on physical growth and development. Dis.Nerv.System **15:** 81-85, Mar. 1954.

Dodd, Katharine: Typhoid fever in children in Arkansas; report of experience at the University Hospital in 1952. J.Arkansas M.Soc. **50:** 174-177, Mar. 1954.

Goldenberg, Marcel, Serlin, I., **Edwards, Theodora,** and others: Chemical screening methods for the diagnosis of pheochromocytoma. I. Nor-epinephrine and epinephrine in human urine. Am.J.Med. **16:** 310-327, Mar. 1954.

Papajoannou, Anna: Brucellosis: diagnosis and treatment. J.Am.M.Women's A. **9:** 79, Mar. 1954.

Felshin, Gertrude: Present status of allergy. J.Am.M. Women's A. **9:** 74-77, Mar. 1954.

Jones, Julia M.: Present trends in the treatment of tuberculosis. J.Am.M.Women's A. **9:** 69-73, Mar. 1954.

Cabrera, Enrique, and **Friedland, Charlotte:** la onda de activacion ventricular en el bloqueo de rama izquierda con infarto: un nuevo signo electrocardiografico. Gac.méd.México **83:** 273-280, July-Aug. 1953. English summary p. 280.

Alimurung, Mariano M., and **Grajo, Maria Z.:** ACTH in the treatment of sarcoidosis. Santo Tomas J.Med. **8:** 376-383, Nov.-Dec. 1953.

Martin, Ruth C., Nowill, W. K., and Stephen, C. R.: An evaluation of succinylcholine. Anesthesiology **15:** 179-187, Mar. 1954.

Selvin, Beatrice: Myanesin: a study in postoperative pain relief. Anesthesiology **15:** 174-178, Mar. 1954.

Ettinger, Alice, and Elkin, M.: Value of plain film in renal mass lesions (tumors and cysts). Radiology **62:** 372-382, Mar. 1954.

Bender, Elisabeth: Die Poliomyelitis-Epidemie 1952 in Köln. Med. Welt **3:** 85-92, Jan. 16, 1954.

Robertson, Elizabeth Chant: Recent trends in therapeutic diets. Canad.Hosp. **31:** 54-56, Mar. 1954.

Tompkins, Edna H.: Measurement of erythrocytic diameters with phase microscopy. J.Lab.&Clin.Med. **43:** 212-214, Feb. 1954.

Spaet, T. H., and **Anderson, Marcia:** Studies on the normal serum panagglutinin active against trypsinated human erythrocytes. III. Panagglutinin titers in infants and young children. J.Lab.&Clin.Med. **43:** 208-211, Feb. 1954.

Gardner, F. H., **Howell, Doris,** and Hirsch, E. O.: Platelet transfusions utilizing plastic equipment. J. Lab.&Clin.Med. **43:** 196-207, Feb. 1954.

Rees, Elisabeth: Acquired syphilis in children. Brit.J. Ven.Dis. **30:** 19-23, Mar. 1954.

Berlin, Chaim, and **Meyrovitz, Clara:** Syphilis in pregnancy. Brit.J.Ven.Dis. **30:** 28-30, Mar. 1954.

Gillespie, Helen: A note on the usefulness of psychiatric clinics for pre-school children. M.Officer **91:** 152-153, Apr. 2, 1954.

Netter, Albert, and **Lambert, Alice:** Les stérilités d'origine ovarienne. Rev. prat. **4:** 295-303, Feb. 1, 1954.

Cobb, Beatrix, Clark, R. L., Jr., Howe, C. D., and others: A psychology program in a cancer research hospital. Texas Rep.Biol.&Med. **12:** 30-38, Spring 1954.

Shaw, Clinton McK., Jr., Goldman, Alfred, Kennamer, Rexford, Kimura, Noboru, **Lindgren, Inga,** and others: Studies on the mechanism of ventricular activity. Am.J.Med. **16:** 490-503, Apr. 1954.

Letters TO THE EDITOR

"I have been informed that the hospitals and medical colleges in Korea are sadly lacking in medical journals and books. I have received from the director of the Seoul Hospital the enclosed list of journals which they would very much like to have. Would it be possible for you to publish this list in the JOURNAL with the hope that readers will be willing to send their journals to women doctors in Korea?

"In order to avoid duplication, it would be better if the donor of the journal would contact me first for me to give her the name of an individual in Korea to whom she could mail the publication.

"I would greatly appreciate your assistance.

"Yours sincerely,
ADA CHREE REID, M.D., 118 Riverside Drive, 3B, New York 24"

American Dietetic Association, Journal
American Heart Journal
American Journal of Anatomy
American Journal of Cancer
American Journal of Clinical Pathology
American Journal of Digestive Diseases
A.M.A. Journal of Diseases of Children
American Journal of Hygiene
American Journal of Medicine
American Journal of Obstetrics and Gynecology
American Journal of Ophthalmology
American Journal of Pathology
American Journal of Pharmacy
American Journal of Physiology
American Journal of Psychiatry
American Journal of Public Health
American Journal of Roentgenology
American Journal of Surgery
American Journal of the Medical Sciences
American Medical Association, Journal
American Pharmaceutical Association, Journal
American Review of Tuberculosis
Annals of Internal Medicine
Annals of Opthalmology
Annals of Otology, Rhinology and Laryngology
Annals of Surgery
Annual Review of Biochemistry
Annual Review of Physiology
Archives of Internal Medicine
Archives of Neurology and Psychiatry
Archives of Ophthalmology and Otology
Archives of Pathology
Archives of Pediatrics
Archives of Surgery
Association of American Medical Colleges, Journal
Australian Journal of Experimental Biology and Medical Science
Bacteriological Reviews
Brain (London)
British Chemical and Physiological Abstracts
British Journal of Experimental Pathology
British Journal of Radiology
British Journal of Surgery
Human Biology
Japanese Journal of the Medical Sciences
Journal of Anti-Biotics (Journal of Penicillin)
Journal of Biochemistry (Tokyo)
Journal of Biological Chemistry (Baltimore)
Journal of General Physiology
Journal of Heredity
Journal of Immunology
Journal of Morphology
Journal of Neurophysiology
Journal of Pediatrics
Journal of Physiology (London)
Journal of Social Hygiene
Parasitology
Physiological Reviews
Postgraduate Medicine
Radiology

EDITORIAL FORECAST

April 1955

The April 1955 issue of the JOURNAL will contain several articles of special interest, and the Minutes of the Mid-Year Board Meeting of the American Medical Women's Association held November 12, 13, and 14, 1954, in Atlanta, Georgia.

"Morphology and a Cure for Cancer," by Thelma B. Dunn, M.D.

"What Makes Us Grow As We Do," by Minnie B. Goldberg, M.D. This was the Woolley Memorial Lecture, presented at the Annual Meeting of the American Medical Women's Association, June 19, 1954, in San Francisco.

"The Psyche and the Skin: Their Interrelationships," by Ruth Ellen Christensen, M.D. Dr. Christensen's article won the award presented by the Publications Committee of the JOURNAL for the best scientific paper submitted for the contest open to women medical students, interns, and residents.

"The Child with Cerebral Palsy and His Family," by Edith Meyer, Ph.D.

"A Mid-Century Look at Woman's Opportunity for Service to Mankind," by Mrs. Dorothy D. Houghton. This speech was presented before the Woman's Medical College of Pennsylvania on June 9, 1954.

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IT HAS BEEN REPORTED—

Blood level determinations for the urinary antibacterial agent furadantin® (Eaton Laboratories), are reported by Dr. Grayson Carroll, associate professor of clinical medicine at St. Louis University, following assays which were unusually delicate because of the low level at which the drug is effective. By contrast, rapid concentration of furadantin in the urine produces high levels there.

Ten patients who received 200 mg. of furadantin as an initial dose showed average blood levels of 0.16 mg. per 100 cc. after one hour, 0.11 mg per 100 cc. after two hours, and 0.08 mg. per 100 cc. after three hours. The amount of the drug recovered in the urine of 9 of the patients showed 21.18 mg. per 100 cc. for the first three-hour collection. Following the initial 200 mg. dose, patients were maintained on 100 mg. of furadantin every six hours for periods ranging from three to eight days. The average blood level after this period of routine medication was 0.18 mg. per 100 cc. and the highest, 0.26 mg.

"It is evident," Dr. Carroll said, "that the blood levels increase with the continuation of the routine dosage of 100 mg. of furadantin given every six hours and that a satisfactory blood level was obtained on practically all patients receiving this type of therapy for at least three days. The presence of an appreciable amount of furadantin in the blood explains the favorable clinical results obtained in some conditions other than urinary infections and may widen the therapeutic field of this drug." A routine initial dosage of 200 mg. is recommended; a dose larger than the usual 100 mg. may also be desirable in severe cases after two or three days.

A high concentration of furadantin in the urine of all patients was found, making it appear that the drug would be "quite effective" in conditions where the urine is retained abnormally.

The blood level determinations were made in collaboration with Dr. Robert V. Brennan and Ruth Jacques.

Respiratory infections in adults have been effectively treated with the mycolytic aerosol detergent Alevaire (Winthrop-Stearns), according to a report in *Annals of Allergy* (12: 611, 1954). The drug was administered by family physicians as the sole medication to 17 adult patients with sinusitis, bronchitis, bronchiectasis and bronchial asthma. Two techniques of inhalation were used: an open top tent method, for overnight therapy, and direct application of a nebulizer equipped with a nasal tip to the external nares, for short periods. All cases were treated at home or in the doctors' offices. The investigators say that experience with infants and children in using Alevaire by inhalation to dissolve bronchial secretions and to moisten mucous membranes in a great many respiratory conditions "led to its empirical use in similar conditions in adults." It is also valuable in anesthesiology to prevent and relieve postoperative atelectasis and pneumonia. The authors found that when used on retained secretions in the sinuses and bronchi, "the degree of benefit was almost exactly correlated with the presence of thick, copious secretions or semi-solid mucous plugs." In all of the patients, the "symptoms of cough, wheezing, dyspnea, and easy fatiguability were greatly benefited." Responses of all patients followed a definite pattern: thinning of secretions, which were more easily expectorated after one or two days of Alevaire therapy; elimination of secretions and symptoms within one to two weeks. Most of the 17 cases were treated with Alevaire alone; some cases of mild sinusitis were successfully treated with only a nose drop mixture containing equal parts of Alevaire and one percent Neo-Synephrine.® The report further suggests a trial of Alevaire "in patients with bronchospasm without apparent secretions."

Satisfactory x-ray films of the urinary tract with no major side effects are provided by a new excretory radiopaque contrast medium called Hypaque (Winthrop-Stearns). Clinical reports indicate that it represents an important advance in terms of the quality of excretory urograms obtained, low toxicity, and high tolerance. Particularly significant was the absence of vein cramp in 99 percent of the cases observed. Following intravenous injection, Hypaque is rapidly carried to the kidneys. Excretion begins almost immediately in normally functioning kidneys, with most of the drug eliminated within two hours and over 90 percent within 24 hours. It was found that a dose of 30 cc. of Hypaque sodium, 50 percent solution, produced dense sharp shadows in the vast majority of adult patients who had previously been partly dehydrated and effectively purged. Clearly defined shadows on film were often obtained five minutes after injection. Visualization of the urinary organs was usually best on films exposed five, ten and fifteen minutes after injection. Hypaque contains 59.87 percent iodine and is highly water soluble. Chemically, the drug is sodium 3, 5-diacetamido-2, 4, 6-triiodobensoate.

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We have been advised—

"AMWA delegates requiring sleeping rooms during the American Medical Association convention can reserve such accommodations *by writing directly to the Reservations Department of THE DENNIS specifying their departure date as not before June 9.* Upon receipt of this reservation, a confirmation will be sent requesting a good faith deposit which will be applied against the room occupancy charge on the nights of Tuesday, June 7, and Wednesday, June 8.

—JOHN E. LEISHMAN, *Director of Sales*
Hotel Dennis, Atlantic City

The Dennis urges that AMWA reservations for June 2-5 be made at once. Demands for AMA reservations make this imperative.

For AMWA reservations use the blank on opposite page.

CONSTITUTION OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

Article III, Section 1a. **Active Members** "shall be members of a Branch, if any local Branch exists; if not, they may be Members-at-large."

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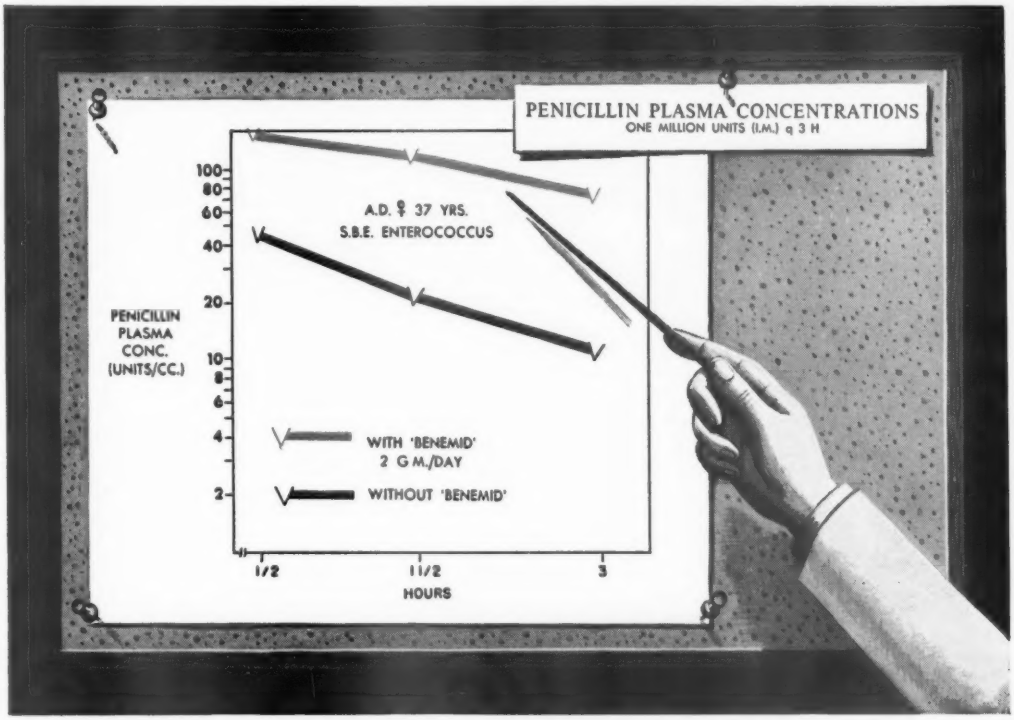

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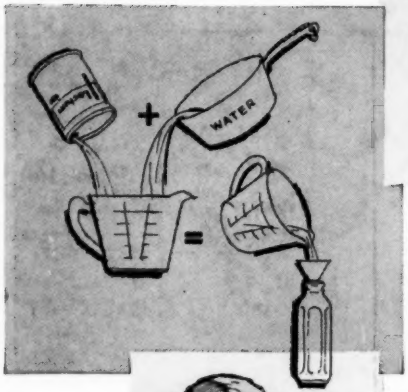

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